REPORT OF THE

JOINT SUBCOMMITTEE TO EVALUATE THE FUTURE DELIVERY OF PUBLICLY FUNDED MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 101

COMMONWEALTH OF VIRGINIA
RICHMOND
2000

Commonwealth of Virginia

GENERAL ASSEMBLY
RICHMOND

January 10, 2000

TO: The Honorable James D. Gilmore, III
and
The General Assembly of Virginia

We are pleased to transmit to you the final report of the *Joint Subcommittee to Evaluate the Future Delivery of Publicly Funded Mental Health, Mental Retardation and Substance Abuse Services*, established by HJR 240 in 1996 and continued by HJR 225 in 1998. The purpose of this study was to conduct a comprehensive evaluation of the Commonwealth's system of delivering publicly funded mental health, mental retardation and substance abuse services.

We wish to express our appreciation to the many individuals who generously shared their time and expertise to assist us in our work, but we want to especially acknowledge the outstanding contributions of one of our members who was also co-chair of this study, Senator Joseph V. Gartlan, Jr.

On many occasions, Senator Gartlan demonstrated how deeply he cares about improving the quality of life for our most vulnerable Virginians and he never failed to remind us of the importance of our task. All who have worked with him know of his legendary ability to penetrate the most complex issues, identify the root problems and create consensus on proposed solutions.

We dedicate this report to Senator Gartlan with our heartfelt thanks and best wishes.

Sincerely,

Delegate Franklin P. Hall, Co-Chair

Delegate Robert S. Bloxom, Vice Chair

Delegate Mary T. Christian

The Honorable Julia A. Connally

Delegate Jay W. DeBoer

The Honorable Mark L. Earley

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Staff

Amy Marschean, Staff Attorney
Gayle Vergara, Senior Research Associate
Nancy Roberts, Manager
Iris A. Kincaid, Operations Staff Assistant
Division of Legislative Services

Susan Massart, House Appropriations Committee
Martha Mead, DMHMRSAS
William Owen, Committee Operations, House of Delegates
Chris Spanos, Consultant

Prologue

When we embarked on this study in 1996, we knew that Virginia's system of publicly funded mental health, mental retardation and substance abuse services was mature and strong in many ways, but also in dire need of new resources and modernization. We traveled extensively around the Commonwealth listening to consumers, family members, advocates and providers carefully and thoughtfully relate their experiences with the services system. Without question, their personal stories had a profound influence on us.

What we found is an undervalued and underfunded system that is rooted in community-based services, but is driven largely by the needs of the state facilities. The system is undervalued because it suffers from severe deficiencies in the facilities that are subject to continuing scrutiny from the Department of Justice and requirements for costly upgrades. Community treatment programs are often viewed as unresponsive to the needs of individuals. Many people are reluctant to seek services due to the attached stigma or lack of information about services. Chronic underfunding results in long waiting lists for services without adequate resources. Sources of funding, such as Medicaid, are not fully utilized. Despite the tremendous social and economic costs of addiction, few state general fund dollars are allocated for the treatment of substance abuse problems in our communities.

Thirty years ago, the Commonwealth adopted a community-based system of publicly funded services to facilitate the discharge of persons who could receive treatment in the communities and to divert individuals from institutionalization in the first place. The concept of community-based services has been reaffirmed through a succession of legislative and executive reviews over the years. Unfortunately, the Commonwealth has failed to follow through with the necessary resources to realize the vision.

Over the last four years, the members of this joint subcommittee, endeavoring to make the vision a reality, have been guided by certain overarching principles. We believe that each individual should be guaranteed the right to participate in planning for his or her future. We believe that people with disabilities have a right to decide where they will live and with whom to the extent possible. We believe that quality should be measured in terms of person-centered, individualized outcomes, not numbers of visits or minutes of care. Most importantly, we believe that we must do all we can to support families in raising their disabled children and help people with disabilities obtain an education and participate in the work force.

Taken together, our recommendations are intended to strengthen the state-local partnership; support community-based services; develop increased accountability, responsibility and collaboration; make optimal use of funding sources and private and public providers; take advantage of treatment innovations; install logical outcome measures for program effectiveness, quality, and consumer and family participation;

respect and protect the human rights of consumers and their families; and provide for infusions of state general funds into a system with documented unmet needs. It is not yet a perfect system, but we believe that we have laid the groundwork and have provided an effective forum for the exchange of ideas to create a vastly improved system.

We wish to thank the many consumers, family members, advocates, providers and agency staff who have monitored the work of the joint subcommittee and generously shared their time, ideas, and comments. Without their help, our work would have been far less complete and we are enormously grateful for their assistance.

Joseph V. Gartlan, Jr. *Senate* *Co-Chairman*	*Franklin P. Hall* *House of Delegates* *Co-Chairman*	*Robert S. Bloxom* *House of Delegates* *Vice Chairman*

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I. Executive Summary

The Joint Subcommittee to Evaluate the Future Delivery of Publicly Funded Mental Health, Mental Retardation and Substance Abuse Services, with active participation by consumers, family members, the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS), community services boards (CSBs) and private providers, has refocused the publicly-funded system from one driven largely by the needs of state facilities to a system that successfully responds to the growing demands for community-based, individualized services. The recommendations of the joint subcommittee, which total 159 over four years, are linked together by four principles: (i) increased accountability for CSBs and state facilities; (ii) increased transition capacity to enable long-term state facility patients to return to their communities; (iii) expanded individual consumer and family-focused services in the communities; and (iv) strengthened consumer protection and advocacy.

Increased Accountability

On the recommendation of the joint subcommittee, the 1998 Session of the General Assembly passed and the Governor signed House Bill 428, which provided important tools for increasing accountability at the state and local levels. Community-based services that meet the individual needs of consumers are at the core of Virginia's publicly-funded system. House Bill 428 established clear administrative relationships between CSBs and local governments and between CSBs and the DMHMRSAS; mandated greater involvement and participation of consumers and family members in policy decision-making and services planning, delivery and evaluation; and provided for strengthened performance contracts between CSBs and the DMHMRSAS. Performance contracts contain specific requirements for receipt of state funding, including consumer outcomes, consumer satisfaction and requirements for standardized cost accounting and financial management systems.

The DMHMRSAS is required by § 37.1-48.1 of the *Code of Virginia* to develop a comprehensive state plan, with biennial updates and revisions to "identify the needs of and the resource requirements for providing services and supports to persons with mental illness, mental retardation or alcohol or other drug abuse problems or dependence across the Commonwealth and propose strategies to address these needs."

The new Performance and Outcomes Measurement System (POMS), which was enthusiastically endorsed by the joint subcommittee, will use the data from CSBs and state facilities to measure access to services, quality and appropriateness of services, human rights, consumer and family involvement, consumer satisfaction, and consumer outcomes. For the first time, the General Assembly, the Governor, consumers, families and the general public will have reliable and consistent data to evaluate consumer services and outcomes.

Increased Transition Capacity

In recent years, admissions and the average daily census have declined significantly for mental health and mental retardation facilities. The availability of new medications, new treatment models, and a broader array of community services have increased community treatment options as alternatives to state facility admissions. The number of individuals who receive CSB services has grown substantially, increasing from 181,799 in 1988 to 208,980 in 1998, as community-based services have increased and diversions from state facilities have been accomplished. CSBs, in consultation with state facilities, are required to prepare discharge plans for individual consumers, with the involvement and participation of the consumer or his representative, prior to the discharge of the person from a state facility to the community. Individualized services plans, which include an array of service and financial options, are approved and monitored by the DMHMRSAS.

Over the last two years, a record increase of $171 million in state general funds has been added to strengthen the system of care for mentally disabled persons in Virginia. Approximately $13.7 million of the increased funding will support the continued census reduction in state facilities, mostly for the purchase of individualized services and special projects. The demand for community services currently exceeds the capacity of the system, although the increased appropriation has helped to reduce the waiting lists for services.

The Program of Assertive Community Treatment (PACT) is a service-delivery model that provides comprehensive, locally-based treatment to people with serious and chronic mental illness. PACT, which has been implemented on a pilot basis, has been instrumental in decreasing the number of admissions to state mental health facilities. Because of PACT's success, the joint subcommittee recommended that the DMHMRSAS and the Department of Medical Assistance Services (DMAS) develop a plan for statewide implementation of PACT.

Expanded Consumer and Family-Focused Services in the Community

On the recommendation of the joint subcommittee, more than $100 million in new state general funds were appropriated for community services in the 1998-2000 biennium. About $52.2 million were added to improve community services for mentally ill citizens and $42 million were added to improve services for mentally retarded citizens. Another $6.8 million in state general funds and $8.2 million in federal funds were appropriated for community substance abuse services. The joint subcommittee's budget recommendations for the 2000-2002 biennium total more than $55 million.

Virginia has historically adopted more restrictive Medicaid criteria than most states, but the joint subcommittee believes that Medicaid is an important financing tool for improving access to community services. For the 2000-2002 biennium, the joint subcommittee recommended: (i) changes in the structure and administration of Medicaid-covered mental health, mental retardation and substance abuse services to enable easier

access to Medicaid covered services in the community; (ii) support for the first-line use of the new antipsychotic medications in Medicaid managed care plans; (iii) new funding to permit incremental increases in the Medicaid "medically needy" income criteria to enable more disabled persons to access Medicaid; (iv) new funding for Medicaid reimbursement for substance abuse treatment; and (v) an interagency task force to streamline procedures and add flexibility to service definitions in the Medicaid mental retardation home-and-community-based waiver.

Virginia's welfare reform efforts, coupled with the effects of a strong economy, have led to almost a 50 percent reduction of Temporary Assistance to Needy Families (TANF) cases. Many of the remaining TANF cases are considered "hard-to-serve" because they experience multiple barriers, including substance abuse, borderline mental retardation, and mental illness. As many as 7,225 TANF clients may have a substance abuse problem at any point in time. The joint subcommittee recognized the need to address substance abuse among TANF clients in its first interim report, House Document 77, in 1998. Since that time, the DMHMRSAS, the Department of Rehabilitative Services, and the Department of Social Services have taken a number of actions to address the issue, including funding, policy changes, local initiatives, and screening, assessment and treatment. The joint subcommittee recommended that these efforts continue and that the departments provide continuing information on the progress of the initiatives.

According to testimony heard by the joint subcommittee, children and adolescents are underserved in the public mental health, mental retardation and substance abuse treatment systems. In addition, families need support services such as respite care, specialized child care, specialized transportation, community-based parenting and support groups, and in-home parent training. Noting the high cost of residential and specialized treatment for children eligible for funding from the Comprehensive Services Act (CSA), the joint subcommittee asked the CSA Executive Council to examine the potential use of unused space in state facilities for residential programs and to develop criteria for providing additional reimbursement for costly specialized care. The joint subcommittee also endorsed the 2000-2002 biennium budget request by the DMHMRSAS for $36.6 million to fund initiatives for children and adolescents who need mental health, mental retardation, and substance abuse treatment in the communities or in juvenile justice facilities.

The joint subcommittee recognized the importance of and requested special reports on (i) the need for adequate housing and residential supports; (ii) appropriate treatment for persons with mental illness, mental retardation or substance abuse problems who reside in adult care residences; (iii) services for persons with traumatic brain injury; (iv) employability of persons with mental disabilities; and (v) the primary health care needs of persons with mental disabilities. Summaries of those reports are included in this document.

Strengthened Consumer Protection and Advocacy

Two distinct statewide programs exist to protect the rights of persons with disabilities: (i) the Office of Human Rights in the DMHMRSAS and (ii) the federal Protection and Advocacy for Individuals with Mental Illness Act and the Developmental Disabilities Assistance and Bill of Rights Act, as administered by the Department for Rights of Virginians with Disabilities.

To strengthen protection and advocacy, the joint subcommittee recommended increased staffing for the Office of Human Rights in the DMHMRSAS and funding and legislation to create a new independent Office of Protection and Advocacy that will include an ombudsman division and sufficient resources to provide protection and advocacy to persons with mental illness who are discharged from state facilities and return to their communities.

What the Future Holds

Much has been accomplished by past legislative studies of the public system of mental health, mental retardation and substance abuse services, as well as the ongoing work of this joint subcommittee. The future will continue to be influenced by improvements in treatment options, advances in information technology, consumer demands, resource availability, and the enforcement and interpretation of state and federal legislation. As the system evolves, continuous oversight and evaluation by the General Assembly will be necessary to ensure that the needs of Virginians with mental disabilities receive the highest priority consideration. Toward that end, the joint subcommittee recommended that a Joint Commission on Behavioral Health Care be created to focus attention on the needs of those persons requiring mental health, mental retardation, and substance abuse services and their families.

II. Review of the Joint Subcommittee's Work

In 1996, the General Assembly passed House Joint Resolution 240 to create a *Joint Subcommittee to Evaluate the Future Delivery of Publicly Funded Mental Health, Mental Retardation and Substance Abuse Services* and to embark upon a comprehensive assessment and restructuring of the publicly funded mental health, mental retardation and substance abuse services system. After two years of intensive study, examination of facilities and programs, and frequent interaction with consumers and families, the joint subcommittee made a number of findings and recommendations that were offered to the 1998 General Assembly. Most of the legislation and budget amendments recommended in the first interim report, House Document No. 77, 1998, were approved by the General Assembly; but the subcommittee's work was not complete, so the General Assembly continued the joint subcommittee for two additional years with the passage of House Joint Resolution 225 (Appendix VI-1) in the 1998 Session.

Historically, the Commonwealth of Virginia has assumed major responsibility for the delivery of services for its citizens with mental disabilities and substance abuse

problems. Originally, state facilities were the major providers of care, but with the mandate for community-based care that emanated from the Hirst Commission (1971) and the Bagley Commission (1980), local community services boards were created across the state. Localities are required by statute to form a community services board or join in a regional effort to provide services to those in their communities.

A. Community-based Services

Community-based services began in the 1950s with state mental health clinics. With the advent of community-based services, the number of persons with mental disabilities or substance abuse problems receiving services through the community services boards has grown steadily. Significant progress has been made in treating people with mental disabilities in the community; 95 percent of mentally disabled persons in the publicly funded system now receive services in the community. New forms of treatment make community care possible for more individuals; a greater array of community services exist; and legal decisions have advanced and mandated the concept of care in "the least restrictive environment."

Recent court cases have begun to spell out the states' responsibility to provide care in the community. The U.S. Supreme Court decision in *Olmstead et al. v. L.C. et al.* (June 1999) affirmed that persons with disabilities who are left to languish in institutions may have suffered discrimination under the federal Americans with Disabilities Act (ADA) by being unjustifiably deprived of any opportunity to live in the community, yet it leaves open the question of a state's responsibility to provide such a community service-delivery system for persons with disabilities.

One of the major goals of the joint subcommittee has been to emphasize the delivery of services to consumers in home-based and community settings. New directives and funding resulting from the 1998 and 1999 sessions of the General Assembly have helped make the goal a reality for many people.

Increased utilization of the community-based treatment system is possible because of:

- The availability of new medications, such as the new antipsychotic drugs;
- Improved medical treatments that serve to extend the life span of individuals and prevent premature deaths in younger persons;
- Individualized philosophies and values for treatment plans;
- New equipment technology to assist the disabled;
- Emphasis on early intervention and prevention;
- Medicaid funding for community-based services for the mentally ill and retarded;
- New models of treatment for the seriously mentally ill, such as Programs of Assertive Community Treatment (PACT); and
- Increased education about the cause and treatment of mental illnesses, mental retardation and substance abuse; the availability of treatment and assistance; and the resulting decrease in stigma associated with seeking treatment.

As a result, the demand for community services currently exceeds the capacity of the current system, although the appropriation of new money in the past two years has reduced the waiting lists.

Numbers of Individuals on Community Services Boards' (CSB) Waiting Lists for Services by Population June 1, 1999[1]

Population	Individuals on CSB Waiting Lists Who are NOT Receiving CSB Services	Individuals on CSB Waiting Lists who ARE Receiving Some CSB Services	Total Number of Persons on CSB Waiting Lists
Adults with Serious Mental Illnesses	1,209	7,875	9,084
Children & Adolescents with or at-risk of Serious Emotional Disturbance	943	3,003	3,946
Individuals with Mental Retardation*	924	4,245	5,169
Adults with Substance Addiction or Abuse	2,094	3,606	5,700
Adolescents with Substance Addiction or Abuse	522	452	974
Total	**5,692**	**19,181**	**24,873**

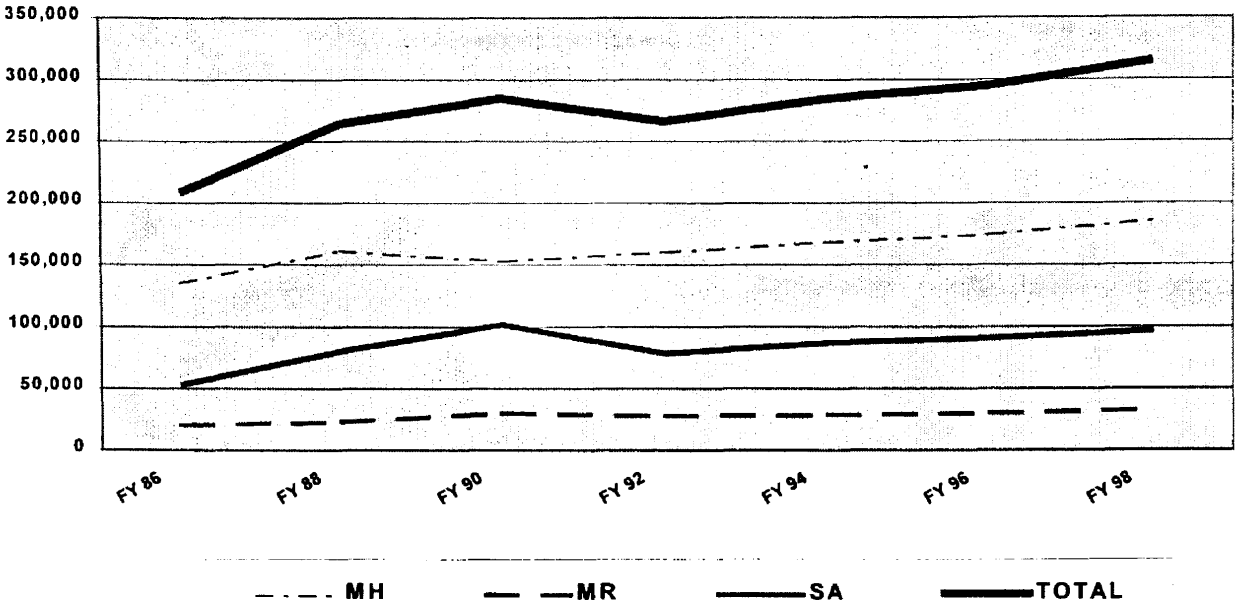
**CSBs did remove individuals from their waiting lists who will be served in FY 2000 through the Governor's initiative to address unmet needs of persons eligible for Mental Retardation Home and Community Based Waiver services. Using an average annualized Mental Retardation Waiver plan total cost of $38,969, an estimated 1,047 of these individuals will receive services in FY 2000.*

In addition to those on the waiting list, recent surveys show that others potentially in need of services include 11,965 Comprehensive Services Act (CSA) or special education graduates, disabled individuals with aging caregivers, and those who were documented by the CSB survey of community needs. If community placements were available, 499 additional training center residents could be discharged.

Between 1986 and fiscal year 1998, the number of persons receiving various CSB services grew (see Figure 1) as community-based services increased and diversions from institutions were accomplished (see Figures 2 and 3).

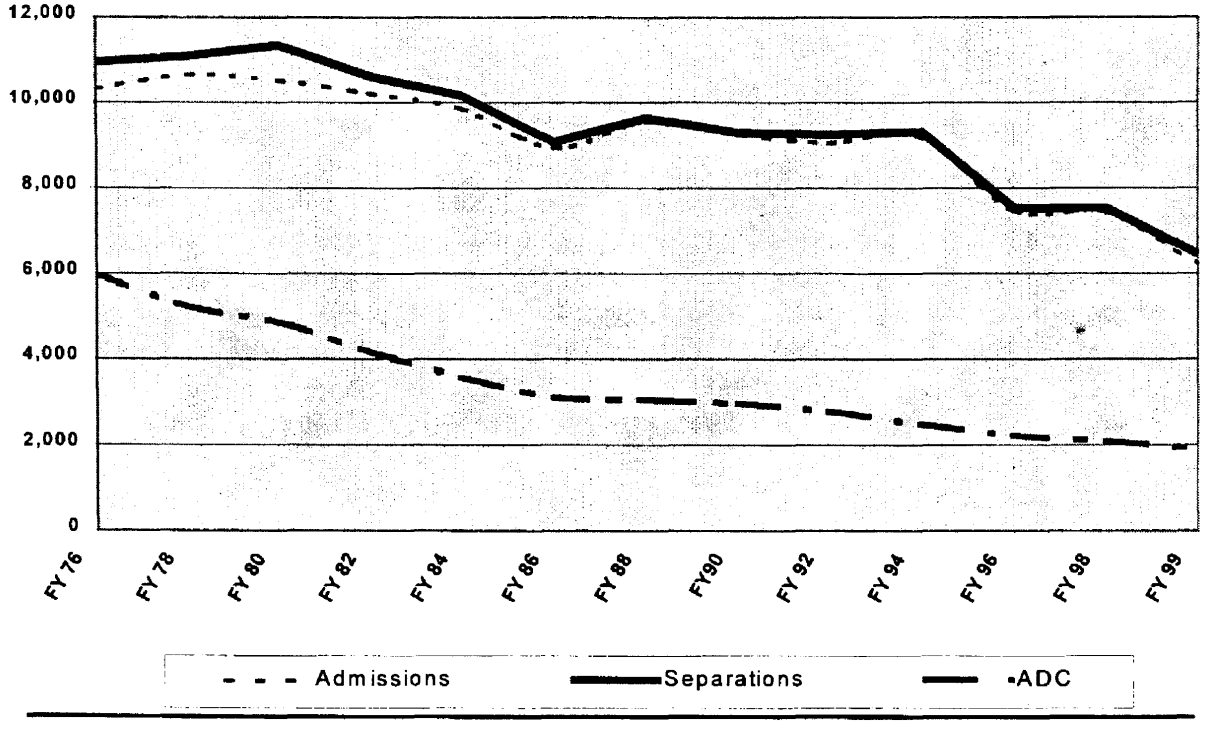
[1] All data relating to waiting lists, system funding and rate of admission can be found in the 2000-2006 Comprehensive State Plan, issued by the DMHMRSAS on January 12, 2000.

Trends in Numbers of Individuals Served by CSBs
FY 1986-1998

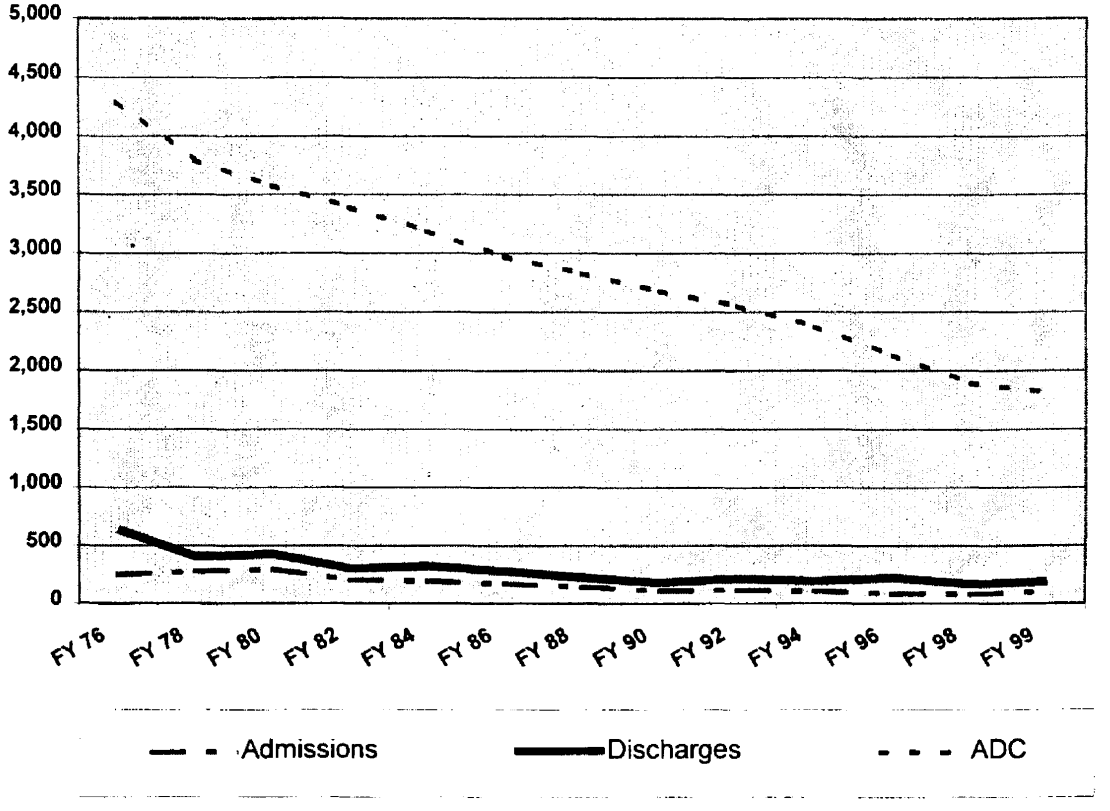


Note: Duplicated (**Dupl.**) numbers of individuals are the total numbers of consumers receiving each category or subcategory of core services. Thus, if a person received outpatient, psychosocial rehabilitation, and supervised residential services, he would be counted three times, since he received three services. These totals are added to calculate a total number for each program area.

MH Admissions, Separations, and Average Daily Census (ADC) Trend
FY 1976-FY 1999



MR Training Center Admissions, Discharges, and Average Daily Census (ADC) Trends
FY 1976-FY 1999



The results of the 1998 and 1999 Sessions of the General Assembly hold great promise for the future delivery of mental health, mental retardation and substance abuse services. Actions taken by the Assembly and the Governor will serve to rectify some long-standing issues, deal with current service delivery, and put the Commonwealth on the road to better, more appropriate, and accountable services to those in need.

In addition to making a number of substantive, structural changes in the method of service delivery, in the past two years a record increase of $171 million in general funds was added to strengthen the system of care for mentally disabled persons in Virginia. In response to hearings held across Virginia by the joint subcommittee, most of this funding was targeted at serving mentally disabled persons in the community.

Of the more than $100 million appropriated for community services, about $52.2 million were added to improve community services for mentally ill citizens and $42 million were added to improve services for mentally retarded citizens. Another $6.8

million in general funds and $8.2 million in federal funds were appropriated for community substance abuse services. Part of the increased funding, about $13.7 million, will support the gradual reduction in census within state facilities. Most of the new funds are allocated for the purchase of individualized services and special projects.

In the 2000 fiscal year, over $50.9 million was disbursed, primarily for community-based services.

Distribution of New Fiscal Year FY 2000 Mental Health and Mental Retardation Funds for Community Services

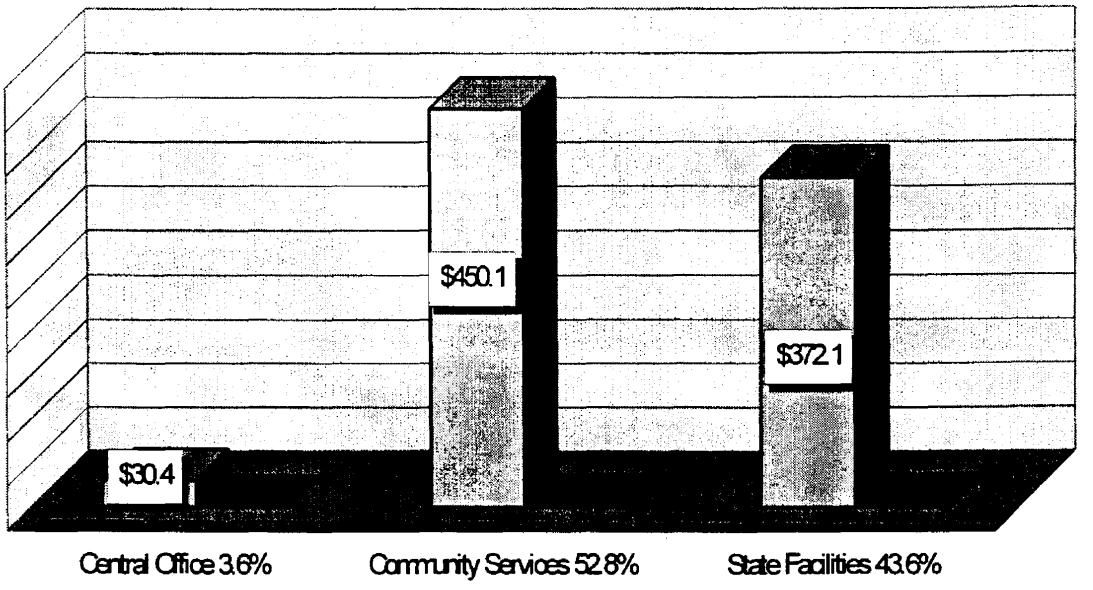
AMOUNT	USE	DISTRIBUTION BASIS
$2,570,847	Public-private partnership for local inpatient psychiatric treatment	Regional request-for-proposal (RFP) by CSBs in Region: four for acute inpatient services tied to 30-bed reduction at Central State Hospital.
$1,032,948	Restoration of juvenile competency (9 months in FY 2000)	The DMHMRSAS will issue RFPs for contracts and disburse funds to contractors. Public and private entities may submit proposals.
$6,169,440	Community atypical antipsychotic medications	Use current method developed by New Medications Committee (funds are credits for CSBs at State Pharmacy).
$5,859,375	Community-based residential services and supports for patients ready to return to communities	Funds for 25 adult bed reductions at Eastern State Hospital and Southwest Virginia Mental Health Institute; 10 bed reductions at Central State Hospital; balance (about 34 beds) for special populations. Used to fund individualized services plans.
$6,500,000	Community residential and support services for persons with mental illness	$50K base to each CSB, balance ($4.5M) distributed through mental health funding formula. CSBs must submit project proposals for approval by the DMHMRSAS.
$750,000	Adult Care Residence Pilot Projects Expansion	$355,000 to each of 2 new sites (Blue Ridge and District 19). Balance of appropriation is for evaluation.
$3,200,000	Programs of Assertive Community Treatment (PACT) Expansion	$600K for new PACTs in Norfolk, Central VA, Region Ten, Arlington, and New River Valley - based on criteria used for first 6 sites (state hospital

AMOUNT	USE	DISTRIBUTION BASIS
		usage); $200K to supplement Henrico's existing PACTs (not funded with special appropriations).
$1,000,000	Children's MH Services	$25K per CSB for intensive in-home, day treatment, or respite services. CSBs submit project proposals for approval by DMHMRSAS.
$5,000,000	Services for Persons Residing with Elderly Caregivers and Persons Losing Other Waivers	Individual plans of care for persons losing other waiver services or living with elderly (65+) caregivers.
$2,500,000	Services for Training Center Residents Ready to Return to Communities	Individual plans of care for approximately 65 people.
$9,195,724	Emergency Community Services	Individual plans of care for persons in three populations: • Special education graduates, 21 and over; • Persons living with aged caregivers and receiving no services; and • Persons currently in need of emergency residential services.
$6,500,000	Day support and supported employment services	Individual plans of care for persons on the DMHMRSAS survey.
$500,000	Family support funds	Steering committee established to set criteria for use and approve requests from families; the DMHMRSAS disburses funds.
$114,000	Cumberland Mountain CSB employment supports	CSB must submit long-term business plan to DRS and the DMHMRSAS.

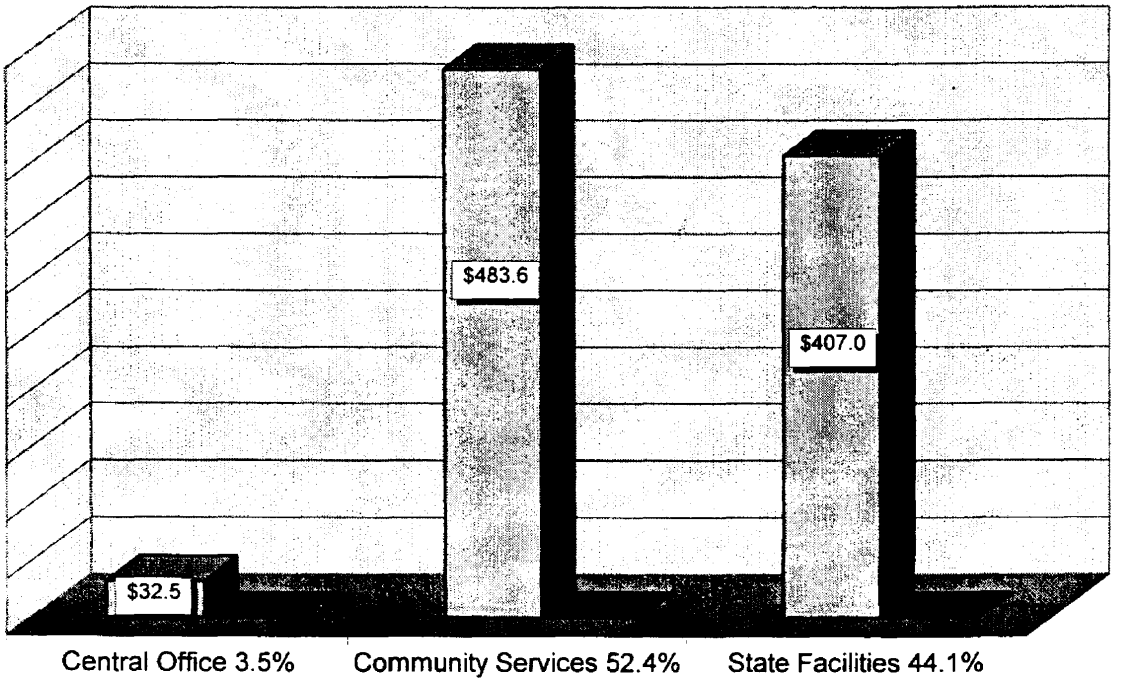
B. Inpatient Services

In addition to improving community services, the General Assembly added about $62.1 million over the biennium to improve care in state institutions and meet federal requirements under the Department of Justice (DOJ) - Civil Rights of Institutionalized Persons Act (CRIPA). Almost $6.9 million were added to measure outcomes and improve techniques for providing high quality care in the publicly funded mental health, mental retardation and substance abuse services system. Between FY 1997 and FY 1998, total services system funding increased to $923.1 million a growth of 8.3% (See Figures 4,5,6 and 7 for expenditures by services and by source.)

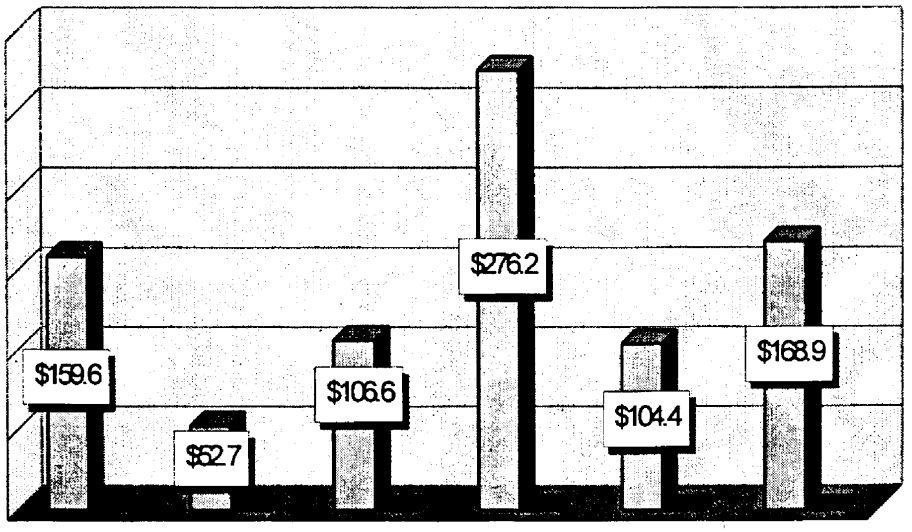
FY 1997 Total Services System Funding
$852.6 Million



FY 1998 Total Services System Funding
$923.2 Million

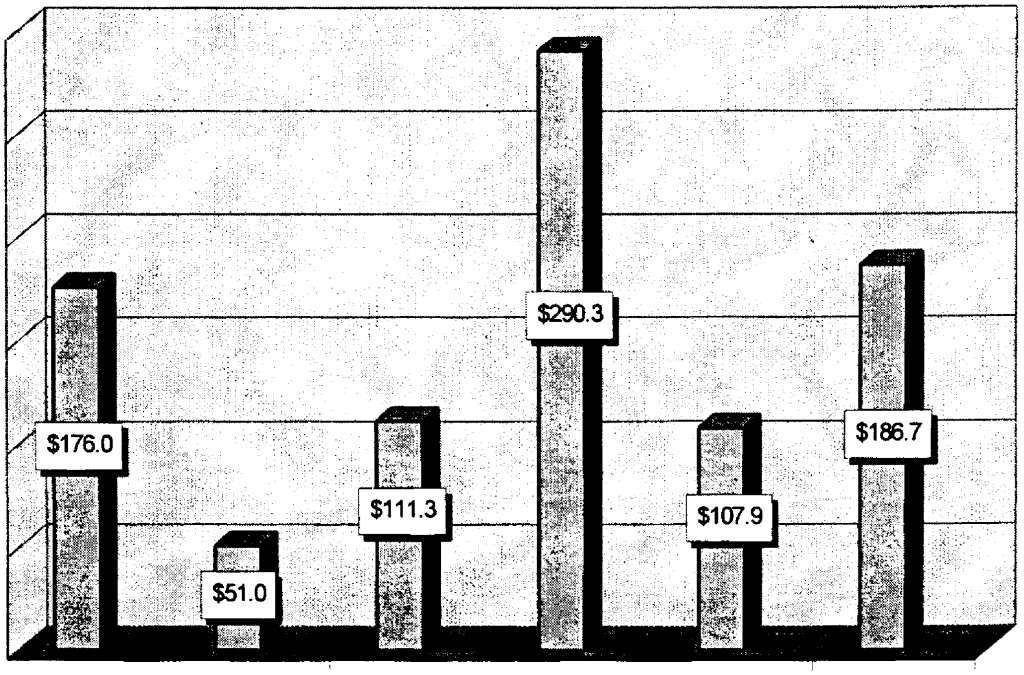


FY 1997 Total Services System Funding By Source
$868.4 Million



Medicaid State 18.7%	Federal Grants 6.2%	Other/Fees 12.5%	State General Fund 32.4%	Local Match 12.2%	Medicaid Federal Share 19.8%

FY 1998 Total Services System Funding By Source
$923.2 Million



Medicaid State 19.1.%	Federal Grants 5.5%	Other/Fees 12.1%	State General Fund 31.4%	Local Match 11.7%	Medicaid Federal Share 20.2%

Although admission rates to facilities have declined substantially and increased numbers of consumers are being treated in the community, facility costs continue to increase. Increased facility costs are the result of several factors, among them: compliance with Medicare and Medicaid certification and accreditation standards; requirements of the federal Department of Justice (DOJ) and the Civil Rights of Institutionalized Persons Act (CRIPA); and greater needs by a higher proportion of seriously mentally ill patients and training center residents who are severely and profoundly retarded.

Facility operating costs have risen 24 percent over the past 10 years (not adjusted for inflation) and $394 million in capital needs over the next six years have been identified. Currently, 100 of the 408 buildings in the system are more than 50 years old, and many buildings require modifications. At the present time, savings resulting from the increased reliance on community care for those who are ready to leave the institutions and for those at-risk of institutionalization are not feasible under the continued impact of the CRIPA requirements and agreements. In addition, savings cannot be realized until large wards or segments of institutions can be downsized.

While the joint subcommittee continues to support the operation of the current 15 mental health and mental retardation facilities, future roles may focus more on specialty services such as forensics, extended rehabilitation, geriatric needs and services to populations with multiple disabilities or significant medical needs. In addition, a commitment has been reiterated regarding the future of trained and experienced staff at the state facilities and the need to provide opportunities for transitioning to expanding community.

C. Values and Structuring

The report of the joint subcommittee, House Document 77 (1998), and resulting legislation were based on certain beliefs about community-based care for persons with mental illness, mental retardation and substance abuse diagnoses: (i) strengthening the current community system with state policy direction; (ii) building comprehensive services that are tailored to individual needs; (iii) providing funding that is packaged for and follows the individual; (iv) creating opportunities for families and consumers to be involved in their treatment; and (v) initiating development of quality indicators that measure outcomes in people's lives rather than units of care. In addition, implementation of managed care practices, such as pre-authorization, utilization management and review, and consumer satisfaction reports, have been integrated into everyday operations of facilities and community services boards.

The joint subcommittee also believes that consumers should have a choice of services and service providers, to the extent possible, and the family or caregiver should be involved as well. Toward that end, the DMHMRSAS established an Office of Consumer Affairs within the Office on Health and Quality Care and administered satisfaction surveys and developed two pilot projects to measure the success of choice within the availability of programs and appropriate financial limits. Results from these

surveys and pilots will help to establish benchmarks and will be part of an ongoing evaluation process.

To measure the degree of family involvement, the DMHMRSAS established the Consumer and Family Involvement Pilot Project to develop "A Plan to Promote Consumer and Family Involvement." The results of the pilot were released and the "lessons learned" were incorporated into the Performance and Outcomes Measurement System (POMS), which will be used in the communities and facilities.

D. Performance and Outcomes Measurement System (POMS)

One of the primary themes during the course of this study has been enhancing the accountability of the services system. A system that examines the outcome of services and the resulting wellbeing of consumers rather than measuring services in terms of units of care or minutes of contact is envisioned. Previous to the inception of this study, the DMHMRSAS had launched an initiative to develop, test, refine, and implement a system for measuring provider performance and consumer outcomes. The joint subcommittee enthusiastically endorsed the concept and has encouraged the DMHMRSAS to continue the POMS project.

Separate sets of performance and outcomes measures and data have been developed for each of five program areas - adult mental health, child mental health, state hospital, substance abuse, and substance abuse prevention. Mental retardation services measures are still under development. Measures for each program are designed to reflect different priorities and the unique characteristics of the population. The performance measures address such issues as access to services, quality and appropriateness of services, human rights, consumer and family involvement, consumer satisfaction and consumer outcomes.

POMS is scheduled to begin data collection on October 1, 2000. The DMHMRSAS recently allocated money to the CSBs for data collection resources required by the surveys and POMS, primarily to hire staff.

E. Priority Populations

Although the joint subcommittee emphasized the need for the development of individualized packages of services for each consumer, it is necessary that the services be directed to the needs of consumers who have the highest priority need for publicly funded services while ensuring that no individual in need of services is denied those services. In its initial report the joint subcommittee indicated that priority populations include adults with serious mental illnesses, children and adolescents with serious emotional disturbances, and individuals with mental retardation and alcohol or other substance abuse or dependence who have lower levels of functioning, more intense service and support needs, and life situations that increase their risk of abuse and exploitation. The joint subcommittee has strongly endorsed the efforts of the DMHMRSAS to use the results of the pilot projects on priority populations to begin to define which consumers

will be served by the state. Included in the discussion are representatives from the DMHMRSAS and CSBs, the Virginia Hospital and Healthcare Association, Virginia Network of Private Providers, and consumer and advocacy groups.

A general consensus has emerged over the past several years among consumers, family members, advocates, the DMHMRSAS, CSBs, and other service providers that individuals with the most serious or severe disabilities, measured in terms of diagnosis, level of functioning, availability of natural supports, and presence of multiple disabilities, should have a priority for receiving services paid with state-controlled funds. (For a more detailed explanation, please refer to Senate Document No. 10, 2000).

According to the plan developed by the DMHMRSAS, the primary intent of priority populations is threefold: (i) to ensure that the services system focuses its use of limited public funds on serving individuals with the greatest need for public services; (ii) to identify individuals whose cost of services would be paid partially or completely with state-controlled funds; and (iii) to identify those individuals who will be included in the POMS evaluation when it becomes effective. State statute does not identify any individual or group of persons as having a legal right to services. Priority population designation does not propose to create such a right; rather, it will be used as a management tool. The DMHMRSAS also states that this designation is not intended to determine, *a priori*, how CSBs should spend their funds or whom they should serve. In future performance contract negotiations, priority populations can serve to identify short-term and long-term expenditures of funds and will serve to increase those funds spent on priority populations.

Priority populations, for the most part, include those persons who need long-term services. Currently, CSBs are statutorily required to provide emergency and pre-admission screening services. Short-term intensive intervention services would be available, within the constraint of available funds, to anyone who needs services to: (i) address an immediate crisis that could escalate to a point where the person becomes a danger to himself or others; (ii) prevent a further deterioration in functioning level or life circumstances that could cause the person to need longer-term services; (iii) improve his ability to function effectively in personal, work or school environments; or (iv) prevent the onset of a mental disability. These services should be available as a safety net for individuals in crisis; many individuals would not need additional services after stabilization. However, persons who need more intensive services for periods of longer than 30 days would have to meet eligibility criteria, which would consider the person's potential risk to himself or others, urgency, clinical diagnosis, and level of functioning. These levels of care and accompanying protocols and evaluation tools are not expected to become immediately effective, but would instead be phased in under a transition plan. Disability-specific priority population checklists have been developed and field-testing has been completed. No additional legislation is anticipated at this time because recent legislation already states that the DMHMRSAS will identify the population to be served with state funds.

F. Role of the DMHMRSAS and CSBs

During the course of the study, much discussion centered on the role of the DMHMRSAS, the relationship between the DMHMRSAS, the CSBs, and their local governments, and linkages between the mental health, mental retardation and substance abuse services system and the academic community. The roles of the DMHMRSAS and CSBs will continue as defined in statute but with an increased emphasis on: planning; data collection and analysis; funding of individualized packages of services; accountability measures, including POMS and performance contracts for CSBs and facilities; defining priority populations; continued oversight and remediation to meet DOJ and CRIPA standards at facilities; and enhanced human rights oversight.

The DMHMRSAS is required by § 37.1-48.1 of the *Code of Virginia* to develop a comprehensive state plan, with biennial updates and revisions to "identify the needs of and the resource requirements for providing services and supports to persons with mental illness, mental retardation or alcohol or other drug abuse problems or dependence across the Commonwealth and propose strategies to address these needs." The goal is to develop an easily applied, consistent and quantifiable methodology to document the unmet needs for services, using the resources available to CSBs, state facilities, consumers and family members, advocacy groups, and local governments.

Although the DMHMRSAS has the overall responsibility for the delivery and general oversight of services, most consumers and families interact with the system on the local level. While mandating individualized packages of services for consumers that meet their needs in the least restrictive environment and with the most appropriate services, the system must also address other philosophical and practical issues. Some have criticized the system that permits CSBs to be a provider of services and also be responsible for coordinating and managing consumers' access to and use of services. Although a separation of functions might be optimal, that solution is not viable in many CSBs because of their size and location and the availability of other service providers. In House Document 77 (1998), the joint subcommittee stated that "while legitimate concerns exist about the possible adverse effect of service monopolies on consumer choice and service efficiency, effectiveness, and responsiveness, it may not always be possible or desirable to organizationally separate case management and direct service provision. Similarly, concerns have been expressed about the potentially negative consequences a rigid separation of these functions would have on service coordination."

The DMHMRSAS has undertaken the responsibility to address some of these issues by identifying strategies that are intended to increase service access, effectiveness and choice through competition. Some of these practices may include contract negotiation, publication and dissemination of report cards, outcome and performance measures, and consumer satisfaction surveys, all of which should be used to evaluate how well the CSBs are doing in this area. The 2000-2002 Appropriation Act directs the DMHMRSAS, in cooperation with CSBs, to develop a plan to clarify the roles and responsibility of CSBs for care coordination and case management.

In addition, to advance the concept of managed care; the DMHMRSAS has established a work group to plan for the development of more sophisticated management oversight systems, such as management information systems, utilization review staff and processes, quality assurance, and consumer involvement. To assist in this project, the DMHMRSAS has examined the feasibility of using an Administrative Services Organization (ASO), to assist in implementing managed care in the communities and facilities. Targets will be for the psychiatric-bed-day allocation system included in the FY 2001 performance contracts. (Because funding was not appropriated, the ASO has not been contracted at this time.) This system will identify specific bed utilization targets for each CSB and include financial incentives or disincentives that would be applied to the CSB. Increased emphasis will be placed on the use of private hospitals for acute short-term psychiatric inpatient services, especially those that qualify for Medicaid reimbursement. To assist in this effort, the DMHMRSAS and the behavioral members of the Virginia Hospital and Healthcare Association (VHHA) have formed a Behavioral Health Forum within the VHHA to work on various census management projects as well as examining the specific proposals and strategies for increasing the participation in policy development, planning, service delivery and oversight and evaluation activities by private providers. Providers who are members of the Virginia Association of HMOs and the Virginia Network of Private Providers also participate.

State facilities may benefit by the institution or expansion of services by private providers, when the initiatives produce economic efficiencies, effectiveness, and service quality, and meet continuity of care issues. Some examples of projects include the privatization of the pharmacies at two state mental health facilities, the provision of laboratory reference services to eight facilities and the establishment of a locum tenens contract to enable facilities to access physician services. The DMHMRSAS also contracted with a private company to staff a medium security unit at the Riverside Regional Jail to relieve census pressure at the Central State Hospital Forensic Unit.

G. Accountability--House Bill 428 (1998)

The relationships between and responsibilities of local governments and community services boards (CSBs) in the publicly-funded mental health, mental retardation, and substance abuse service system have been a central focus of recent system reform. The 1998 General Assembly enacted House Bill 428 (Appendix VI-2), which was recommended by the HJR 225 joint subcommittee.

The bill rewrote almost all of Chapter 10 in Title 37.1 of the *Code of Virginia*, the statute governing delivery of community mental health, mental retardation and substance abuse services. House Bill 428 represented the first significant revision of Chapter 10 since the community system was first established in 1968. The major changes, made by House Bill 428 in the structure and delivery of services, will increase accountability at local and state levels through:

- Clearer relationships between the CSBs and the local governments that established them and between CSBs and the Virginia DMHMRSAS;

- Greater involvement and participation of consumers and their family members in policy and decision-making and services planning, delivery, and evaluation; and
- An enhanced and expanded performance contract that will include consumer outcome, provider performance, consumer satisfaction measures, and comparable and consistent information about costs, services, and consumers.

1. Types of Community Services Boards (CSBs)

Because the structural relationships of CSBs to their local governments vary greatly, accountability has been unclear. House Bill 428 codified the structural differences and clarified those relationships by defining three types of CSBs:

- Operating CSB: The CSB employs its own staff and provides services directly or through contracts with other providers. The CSB is not a city or county government department.
- Administrative Policy CSB: The CSB does not employ its own staff. The CSB's executive director is hired by local government with the board's participation. Services are provided by city or county employees or through contracts with other providers.
- Policy-Advisory CSB: The CSB has no operational powers or duties; it is an advisory board to a local government department that provides services directly or through contracts with other providers.

The law required every city and county that had established or joined a CSB to designate, by July 1, 1998, the type of CSB it has. Local governments can change their designation at any time by ordinance. In the case of multi-jurisdictional CSBs, such a change must be unanimous among all of the jurisdictions.

To date, there are 28 operating CSBs, 10 administrative policy CSBs, one policy-advisory CSB and one behavioral health authority (BHA). House Bill 428 incorporates the statutory authorization for BHAs into Chapter 15 of Title 37.1 of the *Code of Virginia.* BHAs are established to provide the same services that are offered by CSBs.[2] Most provisions applicable to BHAs resemble the powers and duties of operating CSBs in Chapter 10.

[2] Only three localities are authorized to establish BHAs: Chesterfield County, Richmond City and Virginia Beach. To date, only Richmond has actually created a BHA.

1999 Combined Community Services Boards (CSB) Classification (40)

*Budget Size and **Population Density	Operating CSBs(28); Behavioral Health Authority (1)	Administrative Policy CSBs (10); Local Government Department and Policy Advisory CSBs (1)
Large Budget Urban CSBs (10)	Blue Ridge, Hampton-Newport News, Norfolk, Richmond BHA	Alexandria, Arlington, Chesterfield, Fairfax-Falls Church, Henrico Area, Virginia Beach
Medium Budget Urban CSBs (6)	Colonial, Rappahannock Area	Chesapeake, Loudoun County, Portsmouth DBHS, Prince William County
Medium Budget Rural CSBs (14)	Central Virginia, Crossroads, Cumberland Mountain, Danville-Pittsylvania, District 19, Middle Peninsula-Northern Neck, Mount Rogers, New River Valley, Northwestern, Piedmont, Rappahannock-Rapidan, Region Ten, Valley, Western Tidewater	
Small Budget Urban CSB (1)		Hanover County
Small Budget Rural CSBs (9)	Alleghany Highlands, Dickenson County, Eastern Shore, Goochland-Powhatan, Harisonburg-Rockingham, Highlands, Planning District I, Rockbridge Area, Southside	

Notes:

- ***Budget Size** is based on a composite of FY 1998 actual and FY 1999 projected budgets: Large = $13 million plus; Medium = $6 to $13 million; Small = under $6 million
- ****Population density**: Urban = 130 people or more per square mile; Rural = less than 130 people per square mile. Population statistics, based on 1997 Final Population Estimates (University of Virginia Center for Public Service) are current official state population figures, validated with local governments as of February, 1999.

2. CSB Appointments

As a result of House Bill 428, the law now requires that one-third of the appointments to every CSB[3] must be either identified consumers of services or family members of consumers and at least one must be a consumer currently receiving services. The law also increases from one to two the number of local government officials who can be appointed from one jurisdiction to a CSB, and, for the first time, allows appointed officials to serve on CSBs. Finally, the appointment of one or more non-governmental service providers is allowed, as long as the board members and staff of such an organization do not receive any funds from any CSB.

[3] All further references to CSBs in section G should be understood to include local government departments that receive advice from policy-advisory CSBs and behavioral health authorities.

3. New CSB Responsibilities

Also as a result of House Bill 428, operating and administrative policy CSBs and local government departments have additional duties that require them to:

- Take all necessary and appropriate actions to maximize the involvement and participation of consumers and family members in policy formulation and services planning, delivery, and evaluation.
- Institute a consumer dispute resolution mechanism approved by the DMHMRSAS. This mechanism must enable consumers and family members of consumers to resolve concerns, issues, or disagreements about services without adversely affecting their access to or receipt of appropriate types and amounts of current or future services from the board.
- Serve as the single point of entry into the publicly funded mental health, mental retardation and substance abuse services system.
- Develop and submit to the DMHMRSAS the necessary information for the comprehensive state plan required by § 37.1-48.1 of the *Code of Virginia.*
- Provide, in consultation with the appropriate state mental health facility or training center, predischarge planning for any person who, prior to admission, resided in the locality served by the CSB. Until now, state facilities had the lead responsibility for predischarge planning, and CSBs merely cooperated with state facilities. House Bill 428 fundamentally reverses this relationship.

4. Predischarge Planning

As a result of House Bill 428, CSBs are required to complete a predischarge plan prior to the discharge of a person from a state facility. The plan must be prepared with the involvement and participation of the consumer or his or her representative. It must reflect the consumer's preferences to the greatest extent possible. Finally, the plan must include the mental health, mental retardation, substance abuse, social, educational, medical, employment, housing, legal, advocacy, transportation and other services that the consumer will need upon discharge, and it must identify the public or private agencies that have agreed to provide these services.

The law also establishes a process for resolving disagreements between state facilities and CSBs regarding a patient's readiness for discharge. If state facility staff identify a person as ready for discharge and the CSB disagrees, the CSB must document its reasons in the person's treatment plan within 30 days. If the state facility disagrees with the CSB's position and the CSB refuses to develop a predischarge plan, the state facility or CSB must ask the Commissioner of the DMHMRSAS to review the state facility's determination that the person is ready for discharge.

If the Commissioner determines that the person is ready for discharge, the DMHMRSAS will develop a discharge plan. The Commissioner will also determine if

sufficient state-controlled funds to implement the plan have been allocated to the CSB. If sufficient funds have been allocated, the Commissioner may contract with a private provider or another CSB to deliver the services in the plan and withhold funds from the CSB originally responsible for the person's care.

5. CSB Performance Contract

CSBs are required to enter into performance contracts with the DMHMRSAS to obtain state funds. These contracts are the accountability and funding mechanism for community services. The law requires the DMHMRSAS to develop and negotiate the performance contracts. It also requires the DMHMRSAS to make the standard contract form (the language in the contract body) available to the public six months before the start of the fiscal year and to solicit public comments for a period of 60 days.

The law requires the CSB to make its proposed performance contract available for public review and to solicit public comments for a period of 30 days before it is acted upon by the CSB's board of directors. The law also requires the governing body of each local government that established the CSB to approve the performance contract by formal vote before September 15 of each year. The law further states that if the contract is not approved by that date, it is assumed to be approved.

The performance contract:

- Delineates responsibilities of the DMHMRSAS and the CSB;
- Specifies conditions that must be met for the receipt of state-controlled funds by the CSB;
- Identifies the groups of consumers to be served with state-controlled funds;
- Beginning July 1, 2000, contains specific consumer outcome, provider performance, consumer satisfaction, and consumer and family member participation and involvement measures and state facility bed utilization targets that have been negotiated with the CSB;
- Establishes an enforcement mechanism should a CSB fail to comply with any provisions of its contract that includes a notice and appeal process and provisions for remediation, the withholding of funds, repayment of funds, and the DMHMRSAS' termination of the contract; and
- Includes reporting requirements and revenue, cost, service, and consumer information displayed in a consistent, comparable format determined by the DMHMRSAS.

The law authorizes the DMHMRSAS to contract with an administrative services organization to determine whether CSBs are performing in accordance with the requirements of their performance contracts. The law also states that no CSB shall be eligible to receive state-controlled funds after September 15 of each year unless:

- Its performance contract has been approved by the governing body of each local government that established the CSB;

- It provides service, cost, revenue, and aggregate and individual consumer data and information to the DMHMRSAS in a format prescribed by the DMHMRSAS; and
- Starting on July 1, 2000, it uses standardized cost accounting and financial management systems approved by the DMHMRSAS.

Finally, the law authorizes the DMHMRSAS to terminate all or a portion of a CSB's performance contract, if, after unsuccessful use of a remediation process outlined in the contract and, after affording the CSB an adequate opportunity to use the appeal process in the contract, the CSB remains in substantial noncompliance with its contract. After termination of the contract and, after consulting with the local governing body of each local government that established the CSB, the DMHMRSAS may use the state-controlled funds in that contract to negotiate a contract with another CSB or a private organization to obtain services that were the subject of the terminated contract.

The DMHMRSAS is now required by law to disburse state-controlled funds to the CSB in accordance with its performance contract. Allocation of funds to a CSB will be made based on the board's performance. A new criterion for the withdrawal of funds is failure to meet the provider performance, consumer outcome, consumer satisfaction, or consumer and family member involvement and participation measures in the CSB's performance contract.

Due to the substantial changes included in House Bill 428 related to the performance contract, the DMHMRSAS began developing the fiscal year 2000 contract in late summer 1998. The DMHMRSAS established a 25-to-30-person internal central office work group to prepare the first draft of the new contract. The DMHMRSAS distributed the pre-exposure draft on December 7, 1998, to a selected group of representatives of CSBs, consumers, family members, local governments, state facilities, the Department of Medical Assistance Services, and private providers. The DMHMRSAS staff met with these representatives in mid-December to receive comments on the pre-exposure draft. The DMHMRSAS staff revised the pre-exposure draft to reflect these comments and additional suggestions from central office staff.

The DMHMRSAS issued the exposure draft of the fiscal year 2000 community services performance contract on December 31, 1998, for the 60-day public comment period required by § 37.1-198 of the *Code of Virginia*. This comment period ended on March 1, 1999. The DMHMRSAS distributed the exposure draft widely to all CSBs, state facility directors, consumer and family advocacy groups, local government groups, and private providers. The DMHMRSAS also placed the draft on its internet website for other interested individuals to view and download. The DMHMRSAS distributed a guide to the exposure draft to the CSB executive directors and chairmen, state facility directors, members of the State Mental Health, Mental Retardation and Substance Abuse Service Board (State Board) members, the joint subcommittee, and statewide consumer and family member organizations, local government, and private provider organizations.

The DMHMRSAS received comments from more than 70 individuals or organizations representing CSBs, consumers, family members, private providers, and local government officials. The exposure draft generated considerable interest and concerns. Many consumers and family members applauded the emphasis on increased participation and involvement, as did CSBs. However, a number of CSBs and local governments identified concerns related to implementation costs, potential exposure to increased liability, and unfunded mandates on local governments.

Many CSBs indicated their general agreement with the goals and content of the exposure draft, but expressed deep reservations about their ability to implement many provisions in the next fiscal year, particularly in the areas of:

- Care management and coordination (e.g., for state facility care and privately-provided mental retardation waiver services);
- Enrollment and disenrollment;
- Covered populations and services;
- Quality improvement;
- Increased management capacity (for care management); and
- Data reporting.

As a result, the Virginia Association of Community Services Boards (VACSB) and the Virginia Association of Local Human Services Officials (VALHSO) established a small work group to address concerns about the exposure draft. The work group included CSB executive directors, local human services officials, representatives of city and county attorneys, and staff from the Virginia Municipal League and the Virginia Association of Counties. The group invited the DMHMRSAS staff to participate and the DMHMRSAS staff began meeting with the small workgroup in February, 1999.

The DMHMRSAS staff developed a revised draft of the contract, dated March 11, 1999, to reflect the comments, analysis by staff, and input from the Office of the Attorney General. The DMHMRSAS discussed the draft with all CSB Executive Directors on March 16, 1999, and with the VACSB/VALHSO work group on March 18, 1999. As a result of these meetings, the DMHMRSAS staff developed a third draft, which the VACSB/VALHSO work group reviewed on April 13, 1999. The final version of the fiscal year 2000 community services performance contract was issued on April 15, 1999, and was distributed to CSBs, consumer and family member advocacy groups, private provider organizations, local government organizations, state facility directors, State Board members, and other interested individuals.

6. Specific Changes in the Fiscal Year 2000 Performance Contract

The fiscal year 2000 performance contract represents a strengthened and enhanced contract for our publicly-funded services system, as recommended in House Document No. 77 (1998) and envisioned by House Bill 428. The DMHMRSAS has taken the first steps to transition from being a grantor of funds to being a purchaser of quality services by:

- Tailoring services to the specific needs of individuals in identified populations;
- Supporting greater consumer and family member participation;
- Increasing choice among providers;
- Allowing more flexibility for providers in the provision of services;
- Improving responsiveness by providers;
- Enhancing accountability for outcomes at the consumer and provider levels; and
- Fostering greater competition among providers and encouraging more private sector service delivery.

The fiscal year 2000 contract contains specific obligations that the services provider - a CSB, behavioral health authority, or local government department with a policy-advisory CSB - must fulfill. Many of the changes in the new fiscal year 2000 performance contract reflect provisions in House Bill 428. House Bill 428 clearly identifies the CSB as the single-point-of-entry into the publicly funded mental health, mental retardation, and substance abuse services system. House Bill 428 also clearly establishes the CSB's responsibility to provide predischarge planning for its consumers who are ready for discharge, in consultation with the appropriate state facility. These responsibilities are reflected in sections of the performance contract that address continuity of care. The contract requires a CSB to:

- Perform preadmission screening;
- Follow the Continuity of Care Procedures developed by the DMHMRSAS; and
- Provide predischarge planning.

The Continuity of Care Procedures, which are attached to the contract, contain 15 pages of very specific requirements and procedures that address:

- Admission criteria for state facilities;
- Prescreening services and assessments required prior to admission (e.g., medical assessments, substance abuse screening, assessment of mental status, assessment of risk);
- CSB participation on interdisciplinary treatment teams and coordination with the state facility in service planning;
- CSB predischarge planning responsibilities;
- Discharge criteria and resolution of disagreements about readiness for discharge; and
- CSB post-discharge services (e.g., patients to be seen by a CSB psychiatrist within seven days of discharge, follow-up on missed appointments).

The CSB has the following predischarge planning responsibilities in the contract.

- The CSB shall provide predischarge planning for any person, who prior to admission resided in the CSB's service area or who chooses to reside there

after discharge, who is to be discharged from a state facility pursuant to § 37.1-98 of the *Code of Virginia*.

- The predischarge plan shall be completed prior to the person's discharge.
- The predischarge plan shall be prepared with the involvement and participation of the consumer or his representative, and it must reflect the consumer's preferences to the greatest extent possible.
- The predischarge plan shall include the mental health, mental retardation, substance abuse, social, educational, medical, employment, housing, legal, advocacy, transportation, and other services that the consumer will need upon discharge into the community.
- The predischarge plan shall identify the public or private agencies that have agreed to provide these services.

House Bill 428 outlined how disagreements between a CSB and state facility staff about a patient's or resident's readiness for discharge should be handled. The contract contains the following specific procedures for addressing and resolving these disagreements.

- A disagreement about readiness for discharge is solely a clinically-based disagreement between the patient's or resident's facility treatment team and the CSB responsible for the person's care in the community.
- An attachment to the contract describes a panel review process, in which a five-person group reviews the situation and makes a recommendation to the Commissioner regarding the person's readiness for discharge.
- The process has established time limits, to assure timely decision making.
- The Commissioner makes the final determination about the patient's or resident's clinical readiness for discharge.
- If the decision is that the person is ready and the CSB states that it does not have sufficient resources to serve the person, a separate process is used to deal with this issue.
- The process presumes a sufficiency of CSB resources. Given the CSB's statutory identity as the single point of entry into the public system and the statutory mandate for the CSB to provide predischarge planning, there is an expectation that the CSB will use state-controlled funds to implement predischarge plans for its consumers.
- The CSB is responsible for documenting the insufficiency of resources by providing specific information to the DMHMRSAS about current and projected expenditures and revenues, state fund balances from previous fiscal years, and unobligated amounts of state-controlled funds in other program areas that could be used to pay for the patient's or resident's care.
- If the Commissioner determines that sufficient CSB resources are available, the DMHMRSAS will charge the CSB the current per diem rate for each day that the person remains in the state facility beyond the date on which the CSB received the determination that it has sufficient state-controlled funds to serve the person.

- If the CSB refuses to complete the discharge within a specified period of time, the Commissioner will withhold state general or federal funds from the CSB and prepare a predischarge plan and a Request-for-Proposal to purchase the services from another CSB or other qualified public or private provider, in accordance with § 37.1-197.1 of the *Code of Virginia.*

Reflecting the emphasis in House Bill 428 on consumer and family-member involvement and participation, the fiscal year 2000 performance contract contains several provisions to increase such participation. The contract requires the involvement of consumers and family members in treatment planning and services monitoring. It also requires the CSB to offer services that address the cultural and linguistic characteristics of the area and people that it serves. Additionally, it requires the involvement of consumers and family members in the development of individualized services plans and the inclusion of consumers in the CSB's quality improvement efforts. Finally, in response to House Bill 428, the contract requires the CSB to implement a consumer dispute resolution mechanism.

As a result of House Bill 428, current law requires the performance contract to contain state facility utilization targets, starting on July 1, 2000. The contract requires the CSB to participate in the DMHMRSAS's development of these targets during fiscal year 2000. It also requires the performance contract to contain specific consumer outcome, provider performance, consumer satisfaction, and consumer and family member involvement measures, starting on July 1, 2000. The contract requires the CSB to participate in initial Performance and Outcomes Measurement System (POMS) implementation during fiscal year 2000.

Finally, House Bill 428 contained specific provisions that authorize the DMHMRSAS to withdraw funds or terminate the performance contract under certain conditions. Listed in the contract are the disputes that may be resolved through the dispute resolution process in the contract. These include:

- Reduction or withdrawal of funds;
- Termination or suspension of the contract;
- Disputes arising over interpretation or precedence of terms, conditions, or scope of the contract;
- Refusal to negotiate or execute a contract modification;
- Determination that an expenditure is not allowable under the contract; and
- Determination that the contract is void.

The contract defines when the contract may be terminated and describes the remediation process referenced in § 37.1-198 of the *Code of Virginia.* There is a description of the actual dispute resolution process, which includes the ability of the CSB to seek judicial review of the final decision, in accordance with § 11-71 of the *Code of Virginia*, in the Circuit Court for the City of Richmond.

Another important change is the focus on how state-controlled funds are used. State-controlled funds include:

- State general and federal funds appropriated by the legislature;
- Related minimum local matching funds required by § 37.1-199 of the *Code of Virginia*; and
- Medicaid State Plan Option (community mental health rehabilitation services, targeted mental health and mental retardation case management, substance abuse treatment for pregnant and postpartum women and intensive in-home and therapeutic day treatment for children and adolescent services in the Early an Periodic Screening, Diagnosis and Treatment Program) and mental retardation home-and-community-based waiver fees.

The new fiscal year 2000 performance contract identifies three categories of state-controlled funds in the contract.

- Ongoing state-controlled funds are those funds that support the continued provision of existing levels of core services by the CSB, directly or through contracts.
- Purchase of service state-controlled funds are those existing and new funds that are designated to be used to purchase individualized services for consumers who are:

    1. Ready for discharge from state facilities;
    2. At risk of admission to state facilities;
    3. Meet the level of care parameters for state facility admission; or
    4. A member of another identified population group.

    This category includes existing and new mental retardation waiver services. Purchased services are based on individualized services plans developed by the CSB and reviewed and approved by the DMHMRSAS.
- Special project state-controlled funds are those funds that are designated to fund, or are associated with special projects or specific initiatives, such as programs of assertive community treatment (PACT) teams, adult care residence pilots, and regional facility diversion initiatives, including existing PACT and substance abuse diversion projects funded in fiscal year 1999.

The identification of these three categories of state-controlled funds will greatly increase the DMHMRSAS' ability to monitor, track, and account for these funds differently than in the past. Also, over time, more of base-budget grant funding will be transferred into the purchase of individualized services or special projects categories. The DMHMRSAS began this initiative in the new fiscal year 2000 contract by moving all existing mental retardation waiver services from the base budget to the purchase-of-services category and by moving current PACT and substance abuse census-diversion projects from the base budget to special projects category. This approach will provide the economic funding platform for a more managed system of care.

H. Regional Efforts

While many of the issues discussed here are strictly state or local level concerns, there are some issues that demand coordination and cooperation at a higher level than the individual CSB or state facility. Discharge of consumers who are ready to live in the community requires regional planning and service development. Some programs would be greatly enhanced or made more economically viable if accomplished on a regional basis, and new technology, such as telemedicine, can be better utilized.

In addition to the Southwestern Virginia Mental Health Board, other programs have been developed that could assist localities in bed planning for facilities and planning for community placements. Some of these initiatives include the DAD (Discharge and Diversion) project in Northern Virginia, an acute care pilot in the Richmond region, and the model project in Region 4 that is developing a relationship with Virginia Commonwealth University's Medical College of Virginia for training and consultation to individuals with dual diagnoses of mental illness and mental retardation.

III. Current Issues and Recommendations

During the course of its work since the 1998 Session, the joint subcommittee, in addition to maintaining oversight of the implementation of the recommendations offered in House Document 77 (1998), has addressed a number of issues crucial to the development of a more efficient and humane system of mental health, mental retardation and substance abuse services. (Appendix VI-3) contains the status of the recommendations in House Document 77). The most significant issues are Medicaid financing, the revamping and reorganization of the human rights system, children's services, and substance abuse treatment for welfare reform clients.

A. Medicaid Reimbursement

The 1998 Session of the General Assembly directed the joint subcommittee to examine the "impact of a carve-out of Medicaid-financed mental health, mental retardation and substance abuse services from any managed care contracts negotiated with health maintenance organizations and the feasibility of contracting out the administration of all Medicaid-covered mental health, mental retardation and substance abuse services to the DMHMRSAS."

To accomplish the task, a Medicaid work group was formed to determine if a Medicaid carve-out would improve accountability, expand the range and amount of Medicaid covered services, increase access and quality, provide more consumer choice and increase the use of private providers.

During 1998 and 1999, the work group met eleven times to listen to experts, hear public comments and consider issues related to (1) Medicaid eligibility; (2) amount, duration and scope of services; and (3) the structure and financing of Medicaid covered mental health, mental retardation, and substance abuse services. The work group actively

solicited public comments and received many helpful suggestions from consumers, family members, advocates, providers, and agency staff on the various options under consideration. The members took careful account of the comments, and the recommendations are the result of those deliberations.

1. Background

The Virginia Medical Assistance Program (Medicaid) covers a series of mandated and optional services for the treatment of mental illness, mental retardation, and substance abuse problems among Medicaid recipients. The federal government requires that the following services be covered in the *Virginia State Plan for Medical Assistance* outpatient services, including psychiatric services and psychological testing if provided by a medical doctor; inpatient services in a general hospital; and inpatient psychiatric hospital services for individuals under 21 years of age as part of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program.

In addition, Virginia's state plan covers the following optional services: inpatient services provided to persons with mental retardation in an intermediate care facility; mental hospital services for persons 65 and over; outpatient services, including psychiatric services and psychological testing when provided by a licensed clinical psychologist or mental health clinic; mental health and mental retardation community rehabilitation services; and mental retardation home-and-community-based waiver services. Virginia Medicaid covers substance abuse treatment only for pregnant and postpartum women (partial hospitalization and residential services and only one occurrence during a lifetime) and for children if the treatment is part of their EPSDT plan.

Certain intensive behavioral health services, which are provided as community supports to assist individuals to live in their home and communities, are "carved out" of the Medicaid Medallion II managed care program; they are paid on a fee-for-service basis and are not included in the capitation rates paid to health maintenance organization (HMO) contractors. "Carved-out" services include rehabilitation services (day treatment/partial hospitalization, psychosocial rehabilitation, crisis intervention, intensive community treatment, crisis stabilization and mental health support), targeted mental health and mental retardation case management, residential and day support substance abuse treatment for pregnant and postpartum women and intensive in-home and therapeutic day treatment for children and adolescent services in the EPSDT program. Private providers may deliver these services, but initial access is through a CSB.

Virginia has adopted more restrictive Medicaid income eligibility criteria than most states. With less than 70 percent of people who live in poverty eligible for Medicaid, Virginia ranks 43 among the states on this measure. A Virginia Association of Community Services Boards (VACSB) survey indicated that 40 to 55 percent of clinically eligible persons who are seriously mentally ill do not qualify for Medicaid. For many of these individuals, the income threshold for Medicaid is too low to qualify;

moreover, even if qualified, recipients face a disincentive to work because they risk losing their Medicaid eligibility.

In fiscal year 1998, Virginia expenditures for behavioral health care totaled $465.8 million, representing almost 20 percent of all Medicaid expenditures. Approximately 52 percent ($240.1 million) of the Medicaid behavioral health expenditures were paid to hospitals, nursing homes or intermediate care facilities. Approximately, 35 percent ($165.2 million) of Medicaid behavioral health expenditures were paid to community services boards or their contract providers. More than 80 percent ($378.8 million) of Medicaid expenditures for behavioral health were paid on a fee-for-service basis outside of HMO capitation rates.

The Department of Medical Assistance Services (DMAS) reported that not all community mental health, mental retardation, and substance abuse services are available statewide; lack of statewide access places Virginia out of compliance with Health Care Financing Administration (HCFA) requirements. For example, only three CSBs offer day treatment/partial hospitalization for people who are mentally ill; 10 offer day treatment for children and adolescents; two provide residential substance abuse treatment for pregnant women; and three offer crisis supervision or stabilization for people with mental retardation.

In response, CSBs say that restrictive Medicaid criteria and limited funding have affected statewide service accessibility. Because of the complex funding and administrative structure, CSBs must decide whether to provide services and how much Medicaid match they can afford without jeopardizing services to consumers who are ineligible for Medicaid.

2. Eligibility

Compared to most states, Virginia applies more restrictive income and resource criteria to Medicaid eligibility for people with disabilities. Virginia is one of 11 states that adopted the option known as "209(b) of the Social Security Amendment of 1972," which allows states to use eligibility criteria that were in place in 1972 before Supplemental Security Income (SSI) was established. Under this option, however, Virginia is required to allow SSI recipients with incomes in excess of the eligibility criteria to "spend down" their income to a level that would qualify them for Medicaid.

Aged, blind and disabled individuals who receive SSI are "categorically" eligible for Medicaid within specific income and resource limits. Currently, the monthly income limit for one person receiving SSI is $500 per month or $6,000 annually. This amount equals approximately 73 percent of the federal poverty income guideline.

For SSI recipients, the Virginia Medicaid program also applies more restrictive resource criteria. For example, to qualify for SSI, an applicant can exclude the value of his home and all contiguous property. However, Medicaid caps the value of contiguous property that can be excluded for SSI applicants at $5,000. Persons who do not qualify

for cash assistance, but who meet categorical standards (such as being aged, blind, or disabled) may be eligible for Medicaid as "medically needy." These individuals must reduce their countable resources or "spend down" excess income by sustaining medical expenses in order to qualify for Medicaid coverage.

A dramatic inequity exits between Medicaid income eligibility limits for aged, blind and disabled individuals who receive SSI and those aged, blind and disabled individuals who receive their incomes from regular Social Security disability benefits or some other source. In one case, a disabled woman lost Medicaid eligibility when her income increased because she started to draw Social Security disability benefits. The woman had been eligible for Medicaid because she was receiving SSI of $500 per month. She lost SSI when she began to receive $550 per month in Social Security Disability benefits. She was still disabled, but because she no longer received SSI, she had to "spend down" to the "medically needy" income limit of $250 per month to be eligible for Medicaid. A difference of $50 in income per month for this disabled person meant that she had to spend $300 of her meager income each month on medical expenses, often for prescription medications, before she could access Medicaid.

"Medically needy" eligibility is limited due to provisions in federal statute. Originally, income limits were required to be equal to or less than 133 percent of a state's Aid to Dependent Children (ADC) payment standard. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (federal welfare reform law) eliminated the link between the ADC program and Medicaid. For purposes of Medicaid eligibility, the new law "freezes" income, resource and other eligibility criteria under a State's Medicaid plan in effect on July 16, 1996. However, states can opt to increase these income levels by the annual percentage change in the Consumer Price Index. Virginia uses three payment standards, which vary depending on the locality in which an individual resides. Monthly income limits for "medically needy" individuals, which equal approximately 36 percent of the federal poverty income level, are: Group I--$216 ($2,592 annually); Group II--$250 ($3,000 annually); and Group III--$325 ($3,900 annually).

The federal Balanced Budget Act of 1997 permits states to offer a Medicaid "buy-in" option to individuals who meet the SSI disability criteria and who earn up to 250 percent of the federal poverty income guidelines ($20,600 for an individual). These individuals would pay a premium based on a sliding fee scale, which would allow them to keep their Medicaid coverage and work.

RECOMMENDATION 1: *That all persons living below the poverty level should have access to Medicaid coverage if they are categorically eligible and disabled as defined by the Social Security Administration. Steps should be taken in the form of incremental increases in the percentage of income covered by Medicaid up to 100 percent of the poverty level, subject to the Appropriation Act. This recommendation is intended to address the inequity in Medicaid income eligibility limits between Aged, Blind and Disabled individuals who receive Supplemental Security Income (SSI) and those Aged, Blind and Disabled individuals who receive their incomes from regular*

Social Security disability benefits or some other source. The projected state general fund (GF) cost and number of new recipients for each incremental increase in the percentage of the federal poverty level (FPL) are shown in the table below:

Percent FPL	*Cost in Millions FY 2001*	*GF/New Eligibles FY2002*
100% =	*$26.7 (27,270)*	*$27.9 (28,624)*
95% =	*$21.3 (21,816)*	*$22.3 (22,899)*
90% =	*$16.0 (16,362)*	*$16.7 (17,174)*
85% =	*$10.7 (10,908)*	*$11.2 (11,450)*
80% =	*$ 5.3 (5,454)*	*$ 5.6 (5,725)*
75% =	*$ 3.3 (3,409)*	*$ 3.5 (3,578)*

RECOMMENDATION 2: *That the medically needy income limit be increased by the annual percentage change in the Consumer Price Index (CPI), retroactively to July 1, 1996, and subject to the Appropriation Act. This option would add 112 new eligible persons in Fiscal Year 2001 and 225 new persons in Fiscal Year 2002. The general and non-general fund costs, assuming a two- percent CPI adjustment each year, are shown in the table below:*

	FY 2001	***FY 2002***
GF	***$475,205***	***$1,007,073***
NGF	***$510,902***	***$1,084,460***
TOTAL	***$986,107***	***$2,091,533***

RECOMMENDATION 3: *That work should be encouraged and, therefore, consideration should be given to adopting the federal "buy-in" option to cover working disabled individuals with incomes up to 250 percent of the poverty level, consistent with coverage for other disability groups and subject to the Appropriation Act.*

3. Atypical Antipsychotic Medications

The Virginia Chapter of the National Alliance for the Mentally Ill (NAMI-VA) asserts that some Medicaid managed care recipients are having difficulty obtaining or have been denied access to atypical anti-psychotic medications prescribed by their treating physicians. Health maintenance organizations (HMOs) that contract with the DMAS are permitted to establish preferred and standard drug lists, but they must also allow patients access to prescriptions outside of the standard drug list.

In response, DMAS says that all five HMOs participating in Central Virginia's Medallion II program cover the atypical anti-psychotic medications. Two HMOs require physicians to obtain pre-authorization for some atypical anti-psychotic medications and request that patients who are new to psychiatric treatment try a course of at least two standard medications. One HMO, for example, says that approval is weighted most heavily to the physician's perspective and medical recommendation. According to the HMO, 90 percent of the requests for atypical antipsychotic medications are approved for use and the approval remains in place as long as the individual is a member.

Federal law requires that any prior authorization request must be responded to within 24 hours; and in emergency situations, the HMO is required to authorize at least a 72-hour supply of the medication while a decision is being made. In a letter to the Executive Director of NAMI-VA dated May 12, 1999, DMAS asserted that "HMO drug authorization procedures are reasonable and efficient."

The Director of the National Institute of Mental Health, in a letter to the HCFA dated January 1, 1999, stated that no scientific justification exists for requiring patients to fail a course of standard anti-psychotic medications and "consider(s) it ill-advised since, for many people with schizophrenia, their first exposure to anti-psychotic medications may have life long implications for compliance with treatment."

RECOMMENDATION 4: *That the first-line use of the new antipsychotic medications should be supported and budget language should be adopted to eliminate preauthorization requirements for antipsychotic medications prescribed for Medicaid recipients, except where indicated for the safety of the patient. In lieu of preauthorization, budget language is recommended, directing the DMHMRSAS and Medical Assistance Services to develop a plan for retrospective review by HMOs of antipsychotic medications used by Medicaid recipients. The purpose of this recommendation is to increase access to the most effective antipsychotic medications available. The availability of atypical antipsychotic medications is instrumental in preventing the hospitalization and readmission of individuals with serious mental illness.*

4. Program of Assertive Community Treatment

Program of Assertive Community Treatment (PACT) is a service-delivery model that provides comprehensive, locally-based treatment to people with serious and chronic mental illnesses. PACT programs employ interdisciplinary treatment teams, shared caseloads, 24-hour mobile crisis teams, assertive outreach for treatment in the client's own environment, individualized treatment, medication, rehabilitation and supportive services. PACT goes to the consumer whenever and wherever needed. The consumer is not required to adapt to or follow prescriptive rules of a treatment program. In a letter to state Medicaid directors dated June 7, 1999, HCFA cited research that demonstrated the effectiveness of assertive community treatment programs in reducing inpatient use among high-risk patients.

Virginia Medicaid does not currently reimburse PACT as a bundled package of services, although many of the PACT services are reimbursable on a service-by-service basis. DMAS cited the HCFA's past refusal of the bundled rate and its refusal to recognize bundled rates for school-based health services. More recently, however, HCFA has been reexamining the issue.

The VACSB says that PACT effectiveness rests on continuity of care among a defined number of staff, including medical services by physicians and nurses. Under the current requirements, a consumer must be determined to be eligible for each discrete service, each with its own set of authorizations and reauthorizations. In addition, the

volume of services required per consumer far exceeds typical authorizations. For example, PACT consumers typically receive intensive case management provided by a team rather than an individual and for many more hours than other consumers. A bundled rate would relieve some of the administrative burden and paperwork of billing on a service-by-service basis.

RECOMMENDATION 5: *That budget language should be adopted to direct the DMHMRSAS and DMAS to develop a plan for statewide implementation of the PACT, including the identification of costs and cost offsets, general fund match, the necessary waivers, bundled reimbursement, clinical eligibility, rural area access, and the role of the private sector. Included in the plan should be standards that prescribe key elements of PACT treatment and rehabilitation practices: required staff mix and qualifications; minimum staff-to-client ratios; detailed outlines of required treatment; rehabilitation and support services, including assessment and planning; specifications for program operations; eligibility criteria to ensure that PACT services are provided to those in need; and accountability processes to ensure quality outcomes. The Departments shall report to the Chairmen of the House Appropriations and Senate Finance Committees by November 1, 2000.*

5. Mental Retardation Waiver

Item 341 of the 1998 Appropriation Act required the DMHMRSAS and DMAS, in cooperation with community mental retardation service providers, to study the mental retardation waiver and make recommendations to the Governor and the Chairmen of House Appropriations and Senate Finance committees for changes that will lead to greater service efficiencies and cost containment. The report (House Document 61, 1999) contains a number of findings and recommendations related to administration, array of services, service delivery, and financial management.

In FY 1998, 3,172 individuals were served in the mental retardation waiver at a cost of $86.9 million, plus an additional cost of $15.9 million for other Medicaid services. The average Medicaid cost per individual on a waiver is $32,250 per year, compared to the average cost of $63,763 in an intermediate care facility for the mentally retarded (DMAS, December 8, 1999). The DMHMRSAS reports the following numbers of consumers on the waiting list for Mental retardation services as of March 31, 1997: day support--973; supported employment--1,001; residential support--2,897. An additional 2,172 consumers are expected to need residential services within five to 10 years (HD 61). Approximately 2,000 unfilled waiver slots are allocated for individuals to receive services in the communities, depending on available funds.

HD 61 recommends formation of an interagency work group to update the understanding of roles and responsibilities and to streamline procedures between the DMHMRSAS and DMAS. The report also recommends improvements in the service definitions, leading to more flexibility and individualized supports. This recommendation is supported by the Virginia Chapter of the American Congress of Community Supports and Employment Services (ACCSES) which reported to the

Medicaid work group that current definitions and implementation of the mental retardation waiver cause increased costs, reduced options, and increased paper work. Virginia ACCSES recommends the use of best practices from other states, billing units that cover longer periods of time, reduced paper work, elimination of the "medical model" orientation for community services, and a revised rate structure for employment services that encourages work.

Also recommended are improvements to facilitate consumer access, choice, and involvement and the development of quality improvement and monitoring. Noting a conflict of interest, HD 61 recommends that CSBs serve as gatekeepers with services provided by private providers. As an interim step, the report recommends that CSB performance contracts include additional requirements for CSBs that provide services in addition to their management responsibilities. The Virginia Network of Private Providers supports a requirement that any qualified and willing provider should be available as a choice to consumers.

House Document 61 notes that the current system for the flow and tracking of dollars is cumbersome and labor intensive. The report recommends (i) abandonment of the current practice of providing waiver match funds through transfers from CSB appropriations; (ii) that CSBs be provided with sufficient general funds to serve people who are not eligible for the mental retardation waiver; and (iii) adjustments to the rates paid for units of service. Rates were established several years ago, were not based on actual costs, and have not been adjusted.

RECOMMENDATION 6: *That by letter from the Chairmen, an implementation plan and status report should be requested from the DMHMRSAS and DMAS on the recommendations in House Document 61.*

RECOMMENDATION 7: *That language should be included in the 2000-2002 biennium budget that requires action to separate care coordination and case management from service delivery in CSBs. The purpose of this recommendation is to increase consumer choice of providers and eliminate any perceived conflict of interest between these services.*

RECOMMENDATION 8: *That a resolution and budget language should be introduced in the 2000 Session of the General Assembly directing the Secretary of Health and Human Resources to establish an interagency task force to work in conjunction with consumers, families, advocates, community services boards, and private for-profit and non-profit community-based rehabilitation providers, to define roles and responsibilities of the agencies, streamline procedures, examine service definitions, and update the interagency agreement. The Secretary should report to the Governor and the 2001 General Assembly.*

6. Children's Services

The Arc of Virginia asserts that children are underrepresented in the mental retardation services system. Parents and Associates of the Institutionalized Retarded of Virginia (PAIR) recommended increased prevention and early intervention services for developmentally disabled children and children of at-risk parents. DMAS presented data to the Medicaid work group that showed more CSBs provide mental retardation services to adults than to children. For example, 31 CSBs provide in-home residential support to adults; only 22 provide the same service to children. Thirty-five CSBs provide high intensity, center-based day support to adults; only seven provide the service to children. House Document 61 also concluded that the mental retardation waiver has been available more frequently to adults than to children.

For children and adolescents who need mental health treatment, DMAS presented data that showed only 10 CSBs provide day treatment, three provide partial hospitalization, two provide crisis stabilization, and five provide intensive community treatment. Virginia's EPSDT program does not include a formal mental health screen, although any health professional can refer for services. A report by the Bazelon Center for Mental Health Law indicates that many Medicaid-eligible children are going without the care they need because adequate assessments of their mental health have not been made (Bazelon 1994).

The Child and Family Services Task Force of the VACSB reported that the full continuum of care necessary for the successful treatment of children and adolescents is not available because of rigid Medicaid definitions or inflexible service delivery requirements.

RECOMMENDATION 9: *That by budget language, the DMHMRSAS and DMAS should be directed to develop for the 2001 Session of the General Assembly an integrated policy and plan, including the necessary implementing legislation and budget amendments, to provide and improve access by children to mental health and mental retardation services. The plan, integrating the DMHMRSAS, community services boards, court services, Comprehensive Services Act, and Medicaid, should identify: the services needed by children, the cost and source of funding for the services, the strengths and weaknesses of the current service delivery and administrative structure, and opportunities for improvement.*

RECOMMENDATION 10: *That two actions related to the 2000-2002 biennium budget are recommended: (i) By letter to the Governor, request an amendment to the 2000-2002 biennium budget in support of children and adolescent initiatives; (ii) By budget amendment and subject to the Appropriation Act, support the 2000-2002 budget initiatives from the DMHMRSAS, related to children and adolescents: $15.2 million (GF) in FY 2001 and $21.5 million (GF) in FY 2002. The request by the DMHMRSAS covers a range of services and initiatives to reduce waiting lists.*

7. Substance Abuse Services

Based on a recommendation of the joint subcommittee in its first report, House Document 77, the 1998 Appropriation Act directed the DMHMRSAS and DMAS to conduct a feasibility study of expanding Medicaid coverage of substance abuse treatment. The study was to focus on the need, utilization, cost, and cost-benefits of expanded coverage. The Departments retained William M. Mercer, Inc. to provide technical assistance in the development of the report. Mercer estimates that approximately one percent of people age 13 or older who are enrolled in Virginia Medicaid require treatment for substance abuse. On a monthly basis, this proportion amounts to a static population of about 6,000 individuals, or about 18,000 individuals per year, with an average treatment episode of four months. Nearly half of these individuals reside in the catchment areas of 10 CSBs.

National data indicate cost-offsets ranging from five dollars to seven dollars saved for every one dollar spent for treatment. California found that for every dollar spent on treatment, taxpayers saved seven dollars. The state of Washington found significant savings averaging $2,200 per individual in the five years after treatment.

In state fiscal year 1997, CSBs provided substance abuse treatment services to 62,801 unduplicated individuals. An unpublished 1990 paper estimated that approximately 10 percent of the individuals receiving publicly funded substance abuse treatment services were eligible for or enrolled in Medicaid.

The report recommended Medicaid funding for the following substance abuse treatment services for adults and children: emergency services, evaluation and assessment, outpatient (including intensive outpatient), targeted case management; and day treatment. Because HCFA regulations require that residential services to adults be provided in facilities with 16 or fewer beds, and this requirement is difficult to meet on a statewide basis, no residential services for adults were recommended for coverage. However, making the service available to Medicaid-eligible children through the EPSDT program was recommended, since children's services are exempt from the 16-bed requirement.

Funding the suggested array of services would require $4,363,204 (general funds) each year for services to adults and children and $693,047 (general funds) for residential services to children. Total projected general fund appropriation for 2002: $5,056,251. Total biennial general fund appropriation for 2002-2004: $10,112,503.

RECOMMENDATION 11: *That, subject to the Appropriation Act, sufficient general funds ($5.1 million in FY 2002 and $10.1 million in 2002-2004 biennium) should be appropriated to draw down the maximum federal match funds projected for the following array of services: emergency services; outpatient (including intensive outpatient); targeted case management; day treatment; evaluation and assessment; and residential services for children. The funds should be appropriated in stages to accommodate the time required to develop and promulgate regulations through the federal and state process.*

Estimated Cost of Expanded Coverage by Service

Recommended Services	***2002 GF***	***2002-2004 GF***
Emergency	*$ 257,597*	*$ 515,193*
Outpatient	*2,153,697*	*4,307,394*
Targeted Case Management	*481,439*	*962,879*
Day Treatment	*357,589*	*715,178*
Evaluation and Assessment	*1,112,882*	*2,225,764*
Residential for Children	*693,047*	*1,386,095*
Total	***$ 5,056,251***	***$ 10,112,503***

Note: Any differences in totals are due to rounding.

RECOMMENDATION 12: *That DMHMRSAS and DMAS should be directed to select the specific menu of services, which would be required to be available statewide. The purpose of this recommendation is to ensure that the DMHMRSAS, with its expertise in substance abuse treatment, participates in the selection and definition of covered services.*

RECOMMENDATION 13: *That, prior to implementation, the DMHMRSAS and DMAS should be directed to design a process for evaluating the costs and benefits, including cost offsets in other programs, of reimbursement by Medicaid and the Children's Medical Security Insurance Plan for substance abuse treatment in Virginia and require annual reports on findings to the Governor and the General Assembly. An initiative of this kind warrants a thorough evaluation process; however, it is not the intention of the joint subcommittee to delay implementation while an evaluation process is being designed. There are some design prototypes in other states and at the national level and the joint subcommittee requests that the Departments take advantage of the work that has already be accomplished to expedite development of our own design.*

8. Structure and Administration

The General Assembly appropriates funds to both DMAS and the DMHMRSAS for Medicaid-covered mental health, mental retardation, and substance abuse services. While the current structure supports local programs and caps the requirements for general fund match, it is administratively complex, does not comply with federal requirements, limits consumer choice, restricts access, and fragments planning and delivery of Medicaid and non-Medicaid services.

The Work Group initially identified four models for the structure and administration of Medicaid-funded services in the future. (A description of the models and the advantages and disadvantages of each are included in Appendix VI-4). Model I would leave the current model in place. Model II would result in a full "carve-in" of behavioral health services into the Medicaid Medallion II managed care program. Current state plan option and waiver services would be included in at-risk capitated managed care contracts with health maintenance and managed care organizations. In Model III, the DMAS would subcontract the administration of all Medicaid behavioral health services to the DMHMRSAS ("partial carve-out"). Model IV would be a full

"carve out" of all behavioral health services from Medicaid, including Medallion II, to the DMHMRSAS.

During its deliberations, the work group identified a fifth model, a modified Model III. "Alternative Model III" would:

- Partially address CSB concerns about Medicaid match. It would not restore any of the match transferred to DMAS since 1990. However, it would, from July 1, 2000, eliminate any future transfers for new or expanded services that are contained in this partial carve-out beyond the level offered on June 30, 2000.
- Preserve the CSBs' role as the single point of entry into the services system, while eliminating the current perceived CSB monopoly on services and opening up services to direct private-sector provision, rather than as subcontractors to CSBs. CSBs could continue to be service providers, too, but private providers would be able to offer services to consumers directly.
- Significantly enhance opportunities for the private sector to offer services in the publicly funded system. This change would greatly increase choice for consumers by expanding the number of providers offering service.
- Address concerns that have been raised about freedom of choice for consumers and statewide availability of covered Medicaid services.
- Introduce enhanced accountability and efficiency in the provision of services through the use of an administrative services organization (ASO) contracted by the DMHMRSAS.
- Address the concern about the source of match funds.
- Provide an enhanced and formalized policy and regulatory development role for the DMHMRSAS.

RECOMMENDATION 14: *That a modified or Alternative Model III for structure and administration of financing should be adopted. The following paragraphs describe some of the essential features. (A staff paper that describes Alternative Model III in detail is included in Appendix VI-5).*

a) The model (partial carve-out) only applies to Medicaid State Plan Option, mental retardation home and community based waiver, and any other new or expanded mental health, mental retardation, and substance abuse services related to these SPO and mental retardation waiver services subsequently added to the list of covered Medicaid services. For the purposes of Alternative Model III, SPO services mean community mental health rehabilitation services, targeted mental health and mental retardation case management, substance abuse treatment for pregnant and postpartum women and intensive in-home and therapeutic day treatment for children and adolescent services in the EPSDT program.

b) Alternative Model III does not propose changes to existing arrangements for Medicaid funding of state mental health and mental retardation facilities. Medical/surgical inpatient psychiatric, outpatient clinic, and pharmacy

services would remain with DMAS and the Medicaid Medallion II HMOs.

c) *Subcontracted administration to the DMHMRSAS could include provider certification, service authorization (where appropriate, e.g., the mental retardation waiver), utilization review, data collection and analysis, and, subject to DMAS oversight and approval with respect to compliance with federal law, policy and regulatory development for Medicaid SPO, mental retardation home and community-based waiver, and any other new or expanded mental health, mental retardation, and substance abuse services related to these SPO and mental retardation waiver services subsequently added to covered Medicaid services. Some of these functions may be handled by an ASO under contract with the DMHMRSAS.*

d) *DMAS would continue to handle claims payment. Reimbursement for these carved-out services would continue to be on a fee-for-service basis. Capitation and risk sharing arrangements would not be used to fund these services.*

e) *CSBs would function as care coordinators, following specific practice guidelines developed by the DMHMRSAS, and as the single-point-of-entry into the services system for Medicaid SPO, mental retardation waiver, and any other new or expanded mental health, mental retardation, and substance abuse services related to these SPO and waiver services subsequently added to covered Medicaid services. Care coordination is the central service coordination function of CSBs in a managed system of care. Care coordination would be provided exclusively by CSBs and behavioral health authorities. The HJR 240 joint subcommittee recommended that CSBs and behavioral health authorities be local care coordinators and not the primary or only providers of services.*

f) *CSBs would also be responsible, through their performance contracts, for network development. Network development includes identifying or supporting and assisting the establishment of new service providers. This would increase and enhance consumer choice and address issues of "statewideness" and choice. Network development also includes assuring that all qualified private providers can participate in the publicly funded services system and are not excluded from consideration as consumers select providers. The performance contracts that the DMHMRSAS negotiates annually with CSBs would require CSBs and any contracted case managers to inform consumers of all qualified providers that are geographically accessible to them, support and facilitate active and unencumbered consumer choice among providers, and document these actions in the consumer's individual plan of care. Although CSBs are the single point of entry and accountability for the publicly funded mental health, mental retardation and substance abuse community services system, the contractual agreement should ensure that consumers' choices of qualified providers is not limited or constrained.*

g) *All current state funded match for Medicaid SPO and waiver services that has been transferred from the DMHMRSAS appropriation for community services to DMAS and is appropriated to DMAS as of June 30, 2000, would remain in the DMAS base budget.*

h) *On and after July 1, 2000, all additional match that may be needed for SPO and waiver services (above the amount already appropriated in the DMAS base budget) would be requested by DMAS during the budget development process and appropriated to DMAS by the General Assembly. General fund appropriations to the DMHMRSAS and subsequent transfers to DMAS for the following services would not occur: SPO and waiver match or any other new or expanded mental health, mental retardation, and substance abuse services related to these SPO and waiver services subsequently added to the list of covered Medicaid services.*

i) *To minimize possible adverse effects (either of under collections or over collections that DMAS would have to match) that might result from this change, the DMHMRSAS would closely analyze Medicaid fee collection trends during the last half of FY 2000 and make adjustments in each CSB's Medicaid fee allocations and state general fund allocations so that post year-end adjustments for state-funded match would be as small as possible.*

j) *In addition, the DMHMRSAS would allow one final set of adjustments for FY 2000 state general funds for Medicaid federal funds match after the end of the fiscal year. These adjustments would minimize any possible "losses" of state funds for under collecting CSBs and the possible matching fund increases that DMAS would have to seek for CSBs that over collected their Medicaid allocations.*

k) *While the overwhelming proportion of state matching funds for these services is already in the DMAS budget, the fiscal impact of this provision is difficult to project precisely. The impact should be minimal during the first year for SPO services, since private providers have not participated directly in this option to date. Therefore, there may be relatively little private provider participation, and thus growth, in FY 2001. DMAS and the DMHMRSAS should have sufficient information about the mental retardation waiver to be able to predict the need for additional match in the DMAS budget after July 1, 2000, since the waiver is capped at a preset capacity. The only demand for additional state funds for federal funds match in the DMAS budget should come from growth caused by providing currently covered services to additional Medicaid enrollees, providing covered SPO services not currently provided by the CSB or providing new services not previously covered by the State Medical Assistance Plan.*

RECOMMENDATION 15: *That local governments should be required to provide the same amount of local funds used to match state general fund allocations provided by the DMHMRSAS as they provided in the previous fiscal year. This requirement would not apply to services paid for solely with local government funds. Specifically, the following language is proposed for the Appropriation Act, Item 347: "Local governments shall not use state general, special, or federal trust funds provided in this item or state general, special, or federal trust funds provided in Item 335 for mental health, mental retardation, or substance abuse services to supplant their funding effort for mental health, mental retardation and substance abuse services existing as of June 30, 2000."*

RECOMMENDATION 16: *That language should be placed in the Appropriation Act concerning the forecasting of Medicaid utilization for the services contained in this partial Medicaid carve-out. The following language should be inserted at the appropriate places in the FY 2001 Appropriation Act: "The Department of Medical Assistance Services and Department of Planning and Budget, with the assistance of the DMHMRSAS, shall use their Medicaid expenditure forecast models to project expenditures for SPO, mental retardation home and community-based waiver, and any other related new or expanded mental health, mental retardation, and substance abuse services related to these SPO and waiver services subsequently added to the list of covered Medicaid services."*

RECOMMENDATION 17: *That language should be included in the current biennium budget that directs the DMHMRSAS and DMAS to describe their current operational and policy relationships and their plan for implementing Alternative Model III. The Departments should report to the Chairmen of the House Committee on Appropriations and the Senate Committee on Finance by April 28, 2000.*

RECOMMENDATION 18: *That language should be included in the Appropriation Act that directs DMAS to provide claims and expenditure data to the DMHMRSAS about all Medicaid-reimbursed services and information about the recipients of those services. Services include SPO, mental retardation home and community-based waiver, any new or expanded mental health, mental retardation, and substance abuse services related to these SPO and Waiver services subsequently added to covered Medicaid services, medical/surgical inpatient psychiatric, outpatient clinic, and any other behavioral health and mental retardation habilitation services. The ASO contracted by the DMHMRSAS could use this information to increase the effectiveness and efficiency of the services system.*

B. Individual and Family Developmental Disabilities Support Waiver

The 1999 General Assembly, through Item 335LL of the Appropriation Act, directed the Director of the DMAS, with the assistance of a workgroup composed of representatives of various state agencies, consumers, families, advocates and providers, to develop a Medicaid funded home-and- community-based waiver for persons with developmental disabilities, including autism. The Director submitted the results of the

study to the Disability Commission and the joint subcommittee to Evaluate the Future Delivery of Publicly Funded Mental Health, Mental Retardation and Substance Abuse Services in December 1999. A waiver application was submitted to the Health Care Financing Administration (HCFA) in February 2000 and HCFA must respond within 90 days. DMAS must assure HCFA that the average cost to Medicaid of individuals on the waiver will not exceed the average cost to Medicaid of individuals in an intermediate care facility for the mentally retarded. The Governor included $9.1 million in general funds and $9.9 million in non-general funds in his 2000-2002 budget to implement the new waiver in the upcoming biennium.

To be eligible for the waiver, a person must meet the following criteria: (i) he cannot have a diagnosis of mental retardation; (ii) his developmental disability must be attributable to cerebral palsy, epilepsy, or autism or any other condition, other than mental illness, that is closely related to mental retardation; (iii) his disability must have manifested before age 22; and (iv) his disability must be likely to continue indefinitely, resulting in substantial functional limitations in three or more areas of a major life activity. In addition, the individual must meet the intermediate care facility/mental retardation (ICF/MR) level of care, and monthly income cannot exceed 300 percent of the SSI income level, currently $1,500 per month.

Covered services will include support coordination, adult companion services, assistive technology, crisis intervention/stabilization, environmental modifications, in-home residential, day support, skilled nursing, supported employment, therapeutic consultation, respite care, and personal attendant services.

If demand outstrips funding, DMAS proposes to implement a point system to determine who will get priority for services. When determining the priority for who will receive services, DMAS proposes to use the following circumstances of the individual and his family: (i) readiness for discharge from an institution; (ii) possibility of homelessness within 30 days; (iii) availability of only a single caregiver; (iv) aging of caregivers; (v) only caregivers have multiple care giving roles; (vi) risk of harming self or others; (vii) risk of abuse; and (viii) length of time on the waiting list. DMAS proposes to use 55 percent of the funding for plans of care that cost up to $25,000 per year; forty percent of the funding will be allocated for plans of care costing more than $25,000; and five percent of the funding will be reserved for emergencies.

C. Protection of Human Rights for Virginians with Disabilities

Two distinct statewide programs exist to protect the rights of persons with disabilities in Virginia. One program is operated by the Office of Human Rights in the DMHMRSAS pursuant to § 37.1-84.1 of the *Code of Virginia*. Because the DMHMRSAS provides or funds services to some of the same individuals protected by this program, it is commonly referred to as an internal human rights system. Regulations for the internal system are promulgated by the State Mental Health, Mental Retardation and Substance Abuse Services Board (State Board). The other statewide program, known as the external human rights system, is operated by the Department for Rights of

Virginians with Disabilities (DRVD) under the federal Protection and Advocacy for Individuals with Mental Illness Act (PAIMI Act) and the Developmental Disabilities Assistance and Bill of Rights Act (DD Act). Throughout this section, the terms client and consumer are used interchangeably and, where applicable, include patients and residents of state operated or licensed inpatient facilities.

1. Internal DMHMRSAS Human Rights System

What Rights Are Protected. The Office of Human Rights fulfills the legislative mandate of the DMHMRSAS under § 37.1-84.1 of the *Code of Virginia* to assure and protect the legal and human rights of individuals receiving services in facilities or programs operated, licensed or funded by the DMHMRSAS. Section 37.1-84.1 establishes the following nine rights. Each individual shall:

- Retain his legal rights as provided by state and federal law;
- Receive prompt evaluation and treatment or training about which he is informed insofar as he is capable of understanding;
- Be treated with dignity as a human being and be free from abuse;
- Not be the subject of experimental or investigational research without his prior written and informed consent or that of his legally authorized representative;
- Be afforded an opportunity to have access to consultation with a private physician at his own expense and, in the case of hazardous treatment or irreversible surgical procedures, have, upon request, an impartial review prior to implementation, except in case of emergency procedures required for the preservation of his health;
- Be treated under the least restrictive conditions consistent with his condition and not be subjected to unnecessary physical restraint and isolation;
- Be allowed to send and receive sealed letter mail;
- Have access to his medical and mental records and be assured of their confidentiality but, notwithstanding other provisions of law, such right shall be limited to access consistent with sound therapeutic treatment; and
- Have the right to an impartial review of violations of the rights assured under § 37.1-84.1 and the right of access to legal counsel.

The Complaint Process. The Office of Human Rights is administered by the State Human Rights Director (Director) who is employed by and reports to the Commissioner of the DMHMRSAS. The Director has two staff in the DMHMRSAS central office. The Director supervises 18 advocates who work in state facilities and five regional advocates who oversee community programs. All advocates are employed by the Commissioner. They investigate and seek to prevent or to remedy, informally or formally, any alleged rights violations by interviewing and mediating, negotiating, advising, and consulting with consumers and staff, including state facility directors or community services board (CSB) executive directors and their boards of directors. If necessary, advocates file complaints with the Local Human Rights Committee (LHRC) on behalf of a particular client or a class of clients. Complaints concern (i) denial of

application for services; (ii) violations of the regulations; (iii) discrimination; or (iv) harm, abuse, neglect or exploitation of a client.

A LHRC is a committee of community volunteers who provide an oversight function for the facility or community program for which it is appointed. A LHRC for community programs may oversee more than one program or CSB. A LHRC consists of at least five members appointed by the State Human Rights Committee (SHRC). LHRCs review client complaints not resolved at the program level; review and make recommendations concerning variances to the human rights regulations; review program policies, procedures, and practices and make recommendations for change; and conduct investigations.

The SHRC consists of nine volunteers who are broadly representative of various professional and consumer groups and geographic areas of the state. Appointed by the State Board, the SHRC acts as an independent body to oversee the implementation of the human rights program. Its duties are to: receive, coordinate, and evaluate revisions of the regulations; review DMHMRSAS policies, instructions, and standards and make recommendations for revisions; review the scope and content of training programs; monitor and evaluate the implementation and enforcement of the regulations; hear and render decisions on appeals from complaints heard, but not resolved at the LHRC level; and review and approve human rights plans and requests for variances to the regulations.

At the conclusion of a SHRC hearing, the SHRC submits its recommendations to the DMHMRSAS Commissioner. The Commissioner outlines in writing the action to be taken in response to the recommendations of the SHRC or explains why he declines to implement the recommended actions. He forwards his plan of action to the SHRC, LHRC, the state facility director or CSB executive director, and the consumer or his representative. If the SHRC objects in writing to the Commissioner's proposed actions, the Commissioner defers these actions and meets with the SHRC at its next regularly scheduled meeting to attempt to arrange a mutually agreeable course of action. In programs directly operated by the DMHMRSAS, the Commissioner's decision shall be final and binding on all parties, except that, whenever the SHRC believes that the Commissioner's decision is incompatible with the purpose of the regulations, it shall notify the State Board. In programs funded or licensed, but not directly operated, by the DMHMRSAS, the Commissioner may include information relative to proposed future funding or licensure of the program.

Principles for an Internal Human Rights System. The following list of principles for an internal human rights system is derived from presentations made by advocates at the public hearing conducted by the HJR225 joint subcommittee's Human Rights Work Group. An internal human rights system should:

- Integrate into the DMHMRSAS system, providing in-house human rights experts, training in human rights issues, and review of human rights policy and procedures for all programs operated, funded or licensed by the DMHMRSAS.

- Investigate all complaints, thus addressing more of the day-to-day concerns of clients.
- Have equal availability and easily accessible source of assistance for self-advocacy by all clients.
- Provide continuous internal monitoring of the services delivery system at all levels and, thus, promote internal system changes to prevent violations of human rights.
- Receive adequate resources to support the system at all levels and to assure every client immediate, timely, and easy access to an advocate. For example, one regional advocate for many community services boards and thousands of clients is not equivalent to the significantly greater advocate availability and coverage of advocates in state facilities.
- Implement mechanisms for standardization and coordination of rights protection services across all programs (state facilities, community services boards and licensed private providers) and modern information data system for greater accountability.
- Achieve greater consumer involvement and participation statewide and enhanced credibility through the DMHMRSAS's demonstrated commitment to support the human rights protection system and its independence.

Recommendations for Improving the Internal Human Rights System. The effectiveness of the internal human rights system depends upon the leadership and fiscal and administrative support that it receives. The State Board, the DMHRSAS Commissioner, the SHRC, and the State Human Rights Director are, therefore, integral to the system's effectiveness. In the current system, in which conflicts of interest are inherent, credibility is easily compromised. The historic lack of resources is exacerbating the problems in this system. With only 25 staff, the Office of Human Rights oversees 15 state facilities and over 800 DMHMRSAS licensed and funded community programs. These facilities and programs served over 200,000 clients in 1997. The Office of Human Rights addressed 4,513 complaints in 1997. In addition, the Office of Human Rights trains all the DMHMRSAS employees and CSB and licensed program staff on human rights protections.

To date, the DMHMRSAS has placed its human rights emphasis and most of its resources in its state facilities, not in community programs. The 1998 Geller reports on Virginia's mental health hospitals evaluate and make recommendations about organization and staffing, patient populations, psychiatric assessment and diagnosis, treatment planning, psychosocial rehabilitation, medication practices, seclusion and restraint, and safety risks. The reports indicate inadequate staffing and the critical need for additional training of staff to meet the treatment needs of patients. The consultant to the DMHMRSAS found excessive levels of both physical and chemical restraints used at most hospitals, as well as problems in the use of seclusion. The reports also stated that inappropriate admissions occur because there is a serious lack of adequate community placements for patients ready to be discharged and an overall lack of commitment to community placements. Indirectly, the consultant's evaluations can be viewed as a report card on the Commonwealth's internal human rights system. The consultant

independently assessed the quality of care in state psychiatric facilities. The DMHMRSAS central office's direction and oversight to eradicate the systemic problems that were identified necessarily includes a commitment to the internal human rights oversight function in state facilities. While the role of the Office of Human Rights is not quality assurance, the Office does have a legal and regulatory mandate to redress human rights violations and foster human rights protections.

The community human rights system consists of only five regional advocates to assist more than 200,000 Virginians served by CSBs each year, plus other clients in licensed providers not affiliated with CSBs. This virtually nonexistent community human rights system for providers, both public and private, should be strengthened and expanded through restructuring to assure active advocacy for rights protections in CSB and private programs. Although CSB and private programs that are licensed or funded by the DMHMRSAS are required to notify consumers of their rights and the availability of a complaint process, the general public is unaware of the rights protection systems. The LHRCs and regional advocates must establish a much greater presence statewide in order to be effective in addressing community human rights issues. Given the small number of regional advocates, it would also appear to be fairly difficult for most community clients or their family members to contact or receive adequate service from those five advocates.

In 1998, the joint subcommittee made a number of recommendations concerning the internal human rights system that were incorporated in Senate Bill 1224 (Appendix VI-6), which passed in the 1999 General Assembly session:

1. No employee of the DMHMRSAS, a CSB, a CSB contractor, or a licensed private provider may serve as an authorized representative for a consumer being treated in any the DMHMRSAS, CSB or private program or facility, unless such employee, contractor or provider is related by blood to the consumer.

2. A new definition of abuse includes "Use of physical or mechanical restraints on a person that is not in compliance with federal and state laws, regulations, and policies, professionally accepted standards of practice or the person's individualized services plan."

3. The Commissioner can order sanctions for noncompliance with the human rights regulations.

4. Program licensure by the DMHMRSAS is now contingent upon compliance with the human rights statute and regulations.

5. The State Human Rights Committee and Local Human Rights Committees were codified and one-third of all appointments made to these committees must be consumers or family members of consumers. In addition, no employee of the DMHMRSAS, a CSB/BHA, or a program can serve on the LHRC of the program in which he is employed.

6. The law requires all public and private providers to report results of abuse and neglect investigations, deaths and serious injuries, seclusion and restraint data, and findings of human rights violations, including abuse and neglect. This data will be made available to the public.

7. The law provided a new right that individuals receiving services in facilities or programs operated, licensed or funded by the DMHMRSAS "[b]e afforded appropriate opportunities, consistent with the person's capabilities and capacity, to participate in the development and implementation of his individualized services plan."

The joint subcommittee recommends continued support for additional quality staffing and statewide education and outreach.

RECOMMENDATION 19: *That the adequacy of staffing for the Office of Human Rights and its oversight of advocates must be evaluated to assess its capacity to carry out, not only its complaint processing function, but also to engage in education and training on human rights protections statewide in the programs and in the communities to increase awareness of the internal rights protections systems. The DMHMRSAS should provide adequate resources for the Office of Human Rights to provide appropriate oversight of the internal human rights program.*

RECOMMENDATION 20: *That the number, qualifications, competencies, and service of state facility advocates and regional advocates in the Commonwealth must be evaluated to assure that each consumer in a state facility or community program has sufficient access, in terms of timeliness, geography, cultural competence, and communication modalities (e.g., nonverbal speech), to a knowledgeable and skilled advocate. These advocates should be recruited, hired, trained, and supervised by Office of Human Rights personnel.*

RECOMMENDATION 21: *That statewide outreach to consumers must be increased and public awareness campaigns must be conducted regarding human rights protections for people with disabilities. Community outreach should help with recruitment of volunteers for the LHRCs. LHRCs and regional advocates must have enhanced roles, and perhaps greater funding to effectuate those roles. The human rights regulations should be revised to require consolidation of CSB, private provider, and community facility LHRCs into regional committees as recommended by House Document 77. All SHRC and LHRC members should be reimbursed for expenses incurred in the discharge of their duties. There should be at least twice-yearly meetings between the state facility LHRC and the regional community LHRCs sending patients to that facility.*

The proposed revisions to the existing human rights regulations consolidate three existing sets of regulations into one entitled Rules and Regulations to Assure the Rights of Clients in Facilities and Programs Operated, Funded or Licensed by the DMHMRSAS

(proposed regulations), and will apply to all providers of mental health, mental retardation, and substance abuse services, i.e., state facilities, community services boards and licensed private providers. The DMHMRSAS reports that in the new draft human rights regulations, restraint is to be used only as an emergency safety measure, a recommendation of the joint subcommittee in 1998. Also, the new draft human rights regulations include the Commissioner's administrative sanctions. There were many changes made to the regulations in light of Senate Bill 1224 and the results of public comment in Fall 1998, including the comments of this joint subcommittee. According to the DMHMRSAS, the regulations went to the State Board for approval for publication on November 19, 1999, and the effective date of the regulations is anticipated to be during the summer 2000.

RECOMMENDATION 22: That the implementation of the new human rights regulations should be reviewed by a legislative oversight body for an additional two years to assess their adequacy and effectiveness in assuring and protecting the human rights of every client and consumer in facilities and programs operated, licensed or funded by the DMHMRSAS.

2. External Human Rights System

What Rights Are Protected

- The federal Protection and Advocacy for Individuals with Mental Illness Act, through the PAIMI Program, protects the rights of and access to services for individuals with mental illness[4] residing in facilities[5] providing care and treatment for persons with mental illness. The Act also protects individuals whose issue arises within 90 days of discharge from a facility, that provides mental health treatment or services. The Act requires the DRVD to have a PAIMI Advisory Council.

- The federal Developmental Disabilities Assistance and Bill of Rights Act provides funding through the DD program to protection and advocacy organizations to assist people with developmental disabilities, i.e., persons with severe, life-long disabilities manifesting before the age of 22, who require special care, treatment, and services. This includes people with mental retardation and other individuals with various conditions (e.g., cerebral palsy, autism). The Act

[4] According to the PAIMI Act, the term "individual with a mental illness" means an individual—
(A) who has a significant mental illness or emotional impairment, as determined by a mental health professional qualified under the laws and regulations of the State; and
(B) (i) who is an inpatient or resident in a facility rendering care or treatment, even if the whereabouts of such inpatient or resident are unknown;
(ii) who is in the process of being admitted to a facility rendering care or treatment, including persons being transported to such a facility; or
(iii) who is involuntarily confined in a municipal detention facility for reasons other than serving a sentence resulting from conviction for a criminal offense.

[5] According to the PAIMI Act, the term "facilities" may include, but need not be limited to, hospitals, nursing homes, community facilities for individuals with mental illness, board and care homes, homeless shelters, and jails and prisons.

requires DRVD to have a DD Advisory Council since it does not have a governing board.

- The Protection and Advocacy for Individual Rights Program which falls under the Rehabilitation Act of 1973, as amended, provides for advocacy services to persons with disabilities who are not eligible for services under the Client Assistance Program, the DD program, or the PAIMI program.

- The Virginians with Disabilities Act, § 51.5-40 et seq. of the *Code of Virginia,* makes it illegal to discriminate against individuals on the basis of disability in employment, voting, programs or activities conducted by the Commonwealth of Virginia, education, access to public places, transportation, and housing.

- The Client Assistance Program was established as part of the Rehabilitation Act of 1973 to explain and protect the rights of and benefits to persons who are clients of or applicants for services provided by the Department of Rehabilitative Services, Department for the Visually Handicapped, Centers for Independent Living, or programs funded under the Rehabilitation Act of 1973, as amended.

- The Assistive Technology Protection and Advocacy Services Technology-Related Assistance Act for Individuals with Disabilities Program assists individuals with disabilities seeking access to assistive technology devices and services, with emphasis on obtaining funding from vocational rehabilitation and special education providers, Medicaid, or Medicare. The DRVD receives limited funding under a contract from the Virginia Assistive Technology System (VATS) to provide protection and advocacy services to targeted populations under the Assistive Technology program.

Current System and Activities. Under § 51.1-56 of the *Code of Virginia,* the DRVD is created and "assigned to the Secretary of Health and Human Resources and shall be independent of all other agencies reporting to the Secretary. The DRVD shall be headed by a Director who shall be appointed by the Governor, subject to confirmation by the General Assembly." Executive Order 46 (1999) transferred DRVD from the Secretariat of Health and Human Resources to the Secretariat of Administration. In addition, § 51.5-37 states, "no counsel shall be hired by the Department under the provisions of this chapter without the express approval of the Attorney General." Until 1992, the DRVD was allowed to litigate cases "only upon the express approval of the Governor."

In 1999, the DRVD had a director, a deputy director, two managing attorneys, three staff attorneys, seven advocates, a program operations coordinator, an office manager, and an office services specialist. The DRVD also employed on an as-needed basis over 20 private contract attorneys located around the state.

The DRVD provides protection and advocacy services for people with disabilities. The five service strategies employed by the DRVD are information and

DRVD has no state statutory (i) right of access to facilities, (ii) confidentiality protections for its client and/or investigative records, or (iii) notification provision on deaths in state facilities or community programs. It took over a decade for the DRVD to secure an agreement with the DMHMRSAS for its staff to access state mental health and mental retardation facilities and such agreement can be revoked by either party at any time.

Principles for the External Human Rights System. The following list of principles for an external human rights system is derived from presentations made by advocates at the public hearing conducted by the joint subcommittee's human rights work group. An external human rights system should:

- Operate financially and administratively outside the mental health, mental retardation, and substance abuse services delivery system;
- Represent the interests of the client as defined by the client, rather than as defined by providers;
- Use advocacy strategies both inside and outside administrative channels and can be powerful in mobilizing external forces through direct contact with the legislature, governor, citizen's groups, and courts;
- Choose which rights issues to address at a policy level and, therefore, may effect systemic change;
- Address violations of rights both inside and outside the services system when internal systems fail and serves as a watchdog of the internal system; and
- Must receive sufficient resources to operate effectively.

Recommendations for Improving the External Human Rights System. The DRVD's credibility, in terms of public perception of its ability to perform its mission and by its own admission in its Strategic Plan for the 1998-2000 Biennium, is low. Virginia is one of 11 states that continues to designate a state agency as its protection and advocacy (P&A) system. Consumers, disability advocacy organizations, and the press have consistently and repeatedly urged independence for the DRVD's protection and advocacy functions. Further, Governor Gilmore's Five-Point Plan for the Future of Mental Health in Virginia contains the following objective:

> Strengthen the role of the Department for the Rights of Virginians with Disabilities, so that it may serve as an effective and independent watchdog to prevent abuse and neglect of facility residents. According to Governor Gilmore, "I will work closely with advocate groups to design a structure that will safeguard human rights. We need to give the *external* advocate, DRVD, greater independence, just as we need to take a close look at how to improve the *internal* patient advocate system."

Reports of the federal U.S. Department of Education Rehabilitation Services Administration and the Department of Health and Human Services were replete with recommendations for greater independence. For example, one federal report noted, "DRVD press releases must go through the Secretary for approval, the same person responsible for the DMHMRSAS. This clearly suggests a conflict of interest where the

Secretary represents entities whose interests are adverse potentially or in fact." The disability rights community and the press believe that the Office of the Attorney General will not allow the DRVD to engage in meaningful litigation against other state agencies to protect and promote the rights of persons with disabilities. Finally, current DRVD staff are out-of-touch with their constituency. One federal report noted, "Attorneys are almost never in facilities to meet and talk with clients and to monitor conditions. Advocates report visiting large facilities only between once or twice a month to once a quarter."

It is imperative that, as facilities are down-sized and consumers receive more and more treatment in less structured community settings, the Commonwealth has a viable, effective external human rights protection system. Consumers will no longer be protected by the federal Civil Rights of Institutionalized Persons Act (CRIPA)[6] and its resulting Department of Justice monitoring, which applies to state facility settings. A fully-funded and independent DRVD would be able to protect consumers returning to communities through its PAIMI Program, because the PAIMI Act provides the DRVD with jurisdiction over community facilities to protect rights and access to services for residents of those community programs.

While Senate Bill 1224 passed the 1999 Session of the General Assembly, the Governor placed a reenactment clause on the portion relating to the external protection and advocacy independent state agency. The joint subcommittee supports the reenactment of the provisions of Senate Bill 1224 creating the Commonwealth's independent state protection and advocacy agency, the Virginia Office for Protection and Advocacy.

RECOMMENDATION 23: *That the new protection and advocacy agency needs to demonstrate that it has the autonomy and authority to perform its protection and advocacy functions. This should be done by removing the department from the executive branch and creating an independent state agency. The new protection and advocacy agency should have a governing board that is composed of gubernatorial and legislative appointees with staggered terms. It should be governed by an eleven-member board. The appointments should be representative of the state's geographic regions. The Governor should appoint three members of the board who shall be confirmed by the General Assembly. The Speaker of the House of Delegates should appoint four members, and the Senate Committee on Privileges and Elections should appoint four members of the board. The board composition, three gubernatorial and eight legislative appointments, complies with federal law. The governing board should hire the agency director, who, in turn, should retain legal counsel.*

RECOMMENDATION 24: *That the protection and advocacy agency needs increased legal authority to obtain access to facilities and programs, protect the confidentiality of its records and receive notification of critical incident information from*

[6] Civil Rights of Institutionalized Persons Act creates a civil action against a State that is subjecting persons residing in or confined to institutions to egregious or flagrant conditions that deprive such persons of their civil rights.

the internal human rights system administered by the DMHMRSAS. This will enable the new P&A agency to monitor conditions in facilities and programs, conduct investigations regarding alleged violations of rights that have not been addressed satisfactorily by the internal system, and monitor the operations and effectiveness of the internal system.

RECOMMENDATION 25: *That the new protection and advocacy agency needs to maximize its use of resources by having an advocacy program focused on systemic change and consumer education. It needs to build coalitions with constituent groups that are working on similar issues and increase its visibility with respect to state-level policy and legislative initiatives.*

RECOMMENDATION 26: *That the General Assembly should provide sufficient resources to expand the new protection and advocacy agency's capacity for attorney representation of clients, increase staff (advocates, attorneys, and management) visits to facilities and programs to ensure an ongoing presence statewide, and address systemic human rights issues at the policy and legislative levels. Attorneys and all staff should have regular and direct client contact. It is questionable if any protection and advocacy agency can initiate substantive litigation when only using contracted attorneys. Therefore, the number of staff attorneys should be increased significantly.*

RECOMMENDATION 27: *That the new protection and advocacy agency should establish an advocacy or ombudsmen statutory program for receiving complaints and conducting investigations for the purpose of mediating and resolving consumer complaints that are not resolved by the internal system. This would offer an extrajudicial route to address issues and prevent potential over reliance on litigation.*

RECOMMENDATION 28: *That PAIMI Program resources be expanded in order to allow the new protection and advocacy agency to provide protection and advocacy for persons with mental illness who are being released back into communities. CRIPA does not apply to non-institutional settings and the state's protection and advocacy will need to be strengthened to be a more effective and independent watchdog. Maximum employment level for the PAIMI Program would be increased by five for three attorney and two advocate positions for an approximate biennial total of $500,000.*

RECOMMENDATION 29: *That $395,341 for FY 2001 and $372,593 should be appropriated in FY 2002 to fund the new Ombudsman Division in the new Virginia Office for Protection and Advocacy. Maximum employment level would be increased by seven. DRVD included a request for such a division in its budget request to the Governor.*

RECOMMENDATION 30: *That DRVD's staffing and resource levels enable the agency to meet the current statewide need for protection and advocacy services. DRVD submitted a budget request to the Governor for two non-general fund full-time equivalent positions to hire a staff attorney in the Tidewater region and a program operations coordinator. Maximum employment level would be increased by two. Such positions would be funded through federal grant funds: $96,667 in FY 2001 and $104,772 in FY 2002.*

D. Children's Services

Children are a vulnerable population in need of protection and advocacy. Those young children and adolescents with mental disabilities, especially serious emotional disturbances and substance abuse and addiction, can, with early intervention and the proper treatment, go on to live healthy and fulfilling lives. According to the Child and Family Services Task Force of the Virginia Association of Community Services Boards, nationally recognized ideas about the continuum of care needed by children have been adopted in part by some CSBs, but none have been able to fully replicate the model. Without a complete system of care, the existing components are compromised in their availability and effectiveness.

1. Current Needs

Families need support services such as respite, specialized childcare, specialized transportation, community-based parenting and support groups, and in-home parent training. None of these services are currently and specifically funded for children and none are Medicaid-reimbursable.

Other services for children in crisis, such as 24-hour crisis intervention and psychiatric services, family-focused crisis stabilization, inpatient hospitalization and detoxification services, may be Medicaid or private insurance reimbursable. The availability of a range of these services can decrease the need for some inpatient hospitalizations.

There is a dire lack of case management, either targeted or family-focused intensive, for children and their families as some feel has been highlighted by the implementation of the Comprehensive Services Act. Only case management for seriously mentally ill or mentally retarded adults is Medicaid reimbursable. Case management is not reimbursable for chemically dependent adolescents.

In addition, access to outpatient services, intensive community-based treatment, specialized vocational programs, and community-based residential is sorely needed.
Since 1987, the DMHMRSAS has been providing specific guidance to the CSBs on the local development of foundation services necessary to serve children and adolescents with serious emotional disturbances in their communities. The taxonomy for these services is provided in the Mental Health Performance Partnership Grant and includes: emergency services, specialized outpatient services, intensive in-home services, day treatment/education, individual therapeutic homes, case management services, respite care, and family support. A 1998 survey indicated that over 50 percent of all CSBs are providing five or more of these foundation services.

Unfortunately, there is the perception that consensus, unanimity, and agreement on definitions is lacking among the public and private sector regarding children's services. A disparity exists in the provision of services across the Commonwealth, and,

in some instances, none of these specific services are offered by CSBs. The joint subcommittee notes that on occasion, block grants have been given for services, and some CSBs have chosen not to use those funds for children's services, instead using those funds for other programs or populations. This is an issue without resolution, which is unacceptable. Children have always been considered by this joint subcommittee to be a priority population and that remains unchanged.

For the coming biennium, the DMHMRSAS initially requested $36.6 million to fund initiatives for children and adolescents who need mental health, mental retardation, substance abuse or juvenile justice-related treatment.

DMHMRSAS Proposed Budget Initiatives for Children and Adolescents 2000-2002 Biennium

Budget Initiatives	GF FY 2001	GF FY 2002	Biennium Total
Mental Health Services:			
• Add 40 CSB psychiatrists in either child/adolescent, addictions, or general psychiatry*	$ 3,600,000	$ 4,800,000	$ 8,400,000
• Intensive in-home services	422,700	563,600	986,300
• Therapeutic homes	316,300	421,700	738,000
• Family Support	505,500	674,000	1,179,500
• Acute Psychiatric Services	574,300	765,800	1,340,100
Substance Abuse Services:			
• Expand Project Link for pregnant substance abusing women and their children*	150,000	300,000	450,000
• Prevention Services for high-risk youth through mentoring program	30,000	95,000	125,000
Mental Retardation Services			
• Reduce waiting lists for waiver services*	6,700,000	10,000,000	16,700,000
• Reduce waiting lists for persons not eligible for MR waiver*	1,875,500	2,500,900	4,376,400

Budget Initiatives	GF FY 2001	GF FY 2002	Biennium Total
Community Forensic Services:			
• Juveniles in detention centers	262,500	350,000	612,500
• 14 CSB clinicians for juveniles and adults in detention centers and jails*	735,000	980,000	1,715,000
TOTAL	$15,171,800	$21,451,000	$36,622,800

* Services not exclusive to children

RECOMMENDATION 31: *That the DMHMRSAS and the CSBs continue to work together to provide a full array of appropriate services for the treatment of children and adolescents in need of mental health, mental retardation and substance abuse services and to ensure that these services are available to all children of the Commonwealth.*

2. Comprehensive Services Act

Over the past two decades an increasing number of children have developed severe mental, emotional, and social problems that thwart their development as productive adults. Many of these at-risk children share common problems, including residing with dysfunctional families, where they are subject to varying forms of abuse; living in neighborhoods lacking positive role models; and failure at school because of truancy, conduct problems, and learning disabilities.

In 1992, Virginia became one of the first states to implement a statewide comprehensive system of care for children with emotional and behavioral problems. Because services previously were fragmented and outcomes were, therefore, inconsistent and unpredictable due to the many sources of services and funding, the Comprehensive Services Act (CSA), a new service delivery system for at-risk youth, was established to identify multiple funding streams, consolidate them into a single pool of funds, and mandate local service coordination among human service agencies, which then had greater flexibility to develop treatment plans and use community-based services.

When CSA was first implemented in 1994, the program was expected to lower costs, but instead the total cost has continued to increase at an annual rate of 17.6 percent. The total program budget is expected to exceed $200 million in the year 2000 but is also expecting a budget shortfall of approximately $13 million. This growth in the cost of the provision of services under the CSA, according to local government representatives, has strained the budgets of local governments and one of the reasons for some of this growth is the reliance upon expensive, private and out-of-state placements when there are no appropriate programs available in the Commonwealth. According to testimony received, these types of placements, even for just one child in a locality, can exceed the allocation for CSA services in that local government budget.

Because much attention has been directed towards increasing the use of community-based services for those individuals in facilities who are deemed appropriate for such treatment as well as for those persons in the community who are at-risk for facility treatment, it is anticipated that at least portions of some public facilities will be available for alternative uses as patients are discharged. Admissions to mental health facilities has declined steadily over the years, down from 9,880 admissions in 1984 to a projected 3,685 admissions in the year 2000 (62.7% reduction in adult admissions; 3.9% annual average rate of reduction). These facilities have a total of 427 buildings, of which 131 are currently occupied (46 buildings are scheduled for demolition pending availability of capital outlay funding and 36 buildings have been declared surplus). To address the potential uses of some of these underutilized buildings, Senate Joint Resolution 478 was passed by the 1999 General Assembly, requesting this joint subcommittee to establish a special task force to examine whether the buildings could be converted to use for the provision of services to at-risk youth and families under the CSA.

A child qualifying for CSA services must have behavioral or emotional problems that either (i) have persisted over a significant period of time or are of such a critical nature that intervention is warranted, are significantly disabling and present in several community settings, and require services or resources that are unavailable or inaccessible or are beyond normal agency services or which require coordinated intervention by at least two agencies, or (ii) place the child in imminent risk of entering residential care and requiring services or resources that are beyond normal agency services or routine collaborative processes across agencies.

"Mandated" children are primarily those in foster care and special education who need private school placement and must receive any treatment services which they are determined to need and for whom sum-sufficient funds are guaranteed. "Non-mandated" youth, primarily juvenile offenders and children with mental health problems, are not covered by the sum-sufficient language and are served only at the discretion of the locality. Some children not meeting the strict definition become "mandated" when ordered by a judge to receive services. Many judges resort to confinement in the juvenile justice system in order to access services for the child.

The legislative intent of CSA is "to create a collaborative system of service and funding that is child-centered, family-focused, and community-based." The program, as envisioned, would create programs and services to fit the child's needs rather than to fit the child into existing programs. CSA service categories include: family foster care; specialized foster care; therapeutic counseling services; day services; specialized education programs; home-based services; residential care; independent living; case management services; and emergency services. Data for 1998 presented by the Joint Legislative and Audit Review Commission in Senate Document 26 reported that 70 percent of first CSA services were provided in the community, 27 percent were provided in residential settings, and 3 percent were provided in hospital settings.

After study and testimony from providers, parents, and local governments, the task force adopted the following recommendations:

RECOMMENDATION 32: *That the Chair of the CSA State Executive Council, supported by the Office of Comprehensive Services, shall examine the potential for use of underutilized state property under the control of the DMHMRSAS to determine whether the use of underutilized state property, leased to vendors, would reduce the cost of services in the provision of services under the Comprehensive Services Act (CSA), as authorized by the local Community Policy and Management Team (CPMT). If such arrangements are deemed feasible, with the approval of the General Assembly, then the State Executive Council shall take the lead and develop a contracting process with the DMHMRSAS for the leasing of underutilized property to vendors, and facilitate the use of those services through local CPMTs.*

Because children are known to have better treatment outcomes when services are received close to home, and, because in some cases, families need treatment services as well, every attempt shall be made to locate these treatment facilities, if deemed feasible, in an appropriate geographic distribution across the state that allows all children and families to have reasonable access to services. In addition, every consideration shall be given to using the use of facility personnel who may have been subjected to downsizing with the new emphasis on community-based treatment when staffing such treatment facilities, as well as, when creating or capitalizing on regional efforts.

RECOMMENDATION 33: *That the CSA State Executive Council shall move forthwith to select and implement a uniform data system for use by local CPMTs, the Department of Juvenile Justice, and appropriate state agencies as currently mandated by § 2.1-746 of the Code of Virginia. Such a system shall be in place no later than December 31, 2000. The Council shall take into consideration those smaller jurisdictions that because of their low caseloads, may not be required to participate in the computer system but are still required to utilize the same format for reporting purposes. The Council shall initially report their progress in implementing the system to the House Appropriations and the Senate Finance Committees by June 30, 2001 and shall report annually thereafter. Language should be developed for a budget amendment that will assist some localities in the purchase of hardware and programs (many localities have already purchased programs and are already online).*

RECOMMENDATION 34: *That the CSA State Executive Council, with the support of the Office of Comprehensive Services, shall develop criteria for providing additional state reimbursement for those children who must access costly treatment for specialized services. An initial report on the criteria shall be made to the House Appropriations and Senate Finance Committees in October 2000, and the Council shall make annual reports thereafter on the development of the criteria and recommendations for statutory language and budget requests.*

3. KOKAH Project

The 1998 Appropriations Act (Item 347(3)(c)) directed the DMHMRSAS to "conduct an assessment of the Keeping Our Kids At Home (KOKAH) Project to determine the impact of the program in reducing community and institutional costs of care and examine the feasibility, efficacy, and cost-effectiveness of expanding the program statewide." The goal of KOKAH is to reduce Blue Ridge Community Services' utilization of child and adolescent state inpatient facilities, primarily through the purchase of local inpatient and hospital-based day treatment.

Blue Ridge CSB has the eighth highest utilization of state child and adolescent inpatient facilities. Their 1999 utilization rate of 194 bed days per 10,000 youth population is higher than the CSBs' average rate of 110 bed days per 10,000 youth. It is also higher than the average 140 bed days per 10,000 youth population for demographically comparable CSBs. Since the implementation of the KOKAH Project, Blue Ridge has been able to decrease the number of state hospital bed days to within the comparable range of other CSBs. State facility bed days were reduced from 2,459 in fiscal year 1995 to 1,096 in fiscal year 1999, a reduction of 55 percent.

The cost of care is lowest for children and adolescents diverted to community-based services. The cost of care is lower for children and adolescents admitted to local, private hospitals for inpatient services than for children and adolescents admitted to state inpatient facilities. The cost avoidance from use of local inpatient private hospitals is due to significantly shorter lengths of stay for children and adolescents.

The DMHMRSAS concluded that there appears to be sufficient private child and adolescent inpatient psychiatric bed availability and capacity. Thirty-five CSBs are within a 50-mile radius of a private psychiatric hospital that serves children or adolescents. There appears to be moderate community-based service capacity, and over 55 percent of the CSBs provide five or more foundation community-based services to children and adolescents. Foundation services include emergency, specialized outpatient, intensive in-home, day treatment/education, therapeutic home, case management, respite, and family support services.

RECOMMENDATION 35: *That the joint subcommittee support the DMHMRSAS' recommendation that a pilot of a modified KOKAH be implemented in each of the health planning regions of the state. The KOKAH model should be modified to include less reliance on local inpatient hospitalization, a broader array of community-based diversion and step-down services, and standards for hospital utilization rates. A grant of flexible dollars should be awarded to each pilot site to purchase and implement an array of services, with an emphasis on community-based services and including purchase of local inpatient treatment. The development of standardized risk assessment and clinical guidelines to support decision-making regarding the use of local private facilities and state inpatient facilities is also recommended.*

E. Substance Abuse Treatment and Welfare Reform

The 1996 Personal Responsibility and Work Opportunity Reconciliation Act established the Temporary Assistance to Needy Families (TANF) program to provide assistance to families to encourage intact families, provide care for children, and promote work. Rather than reimbursing states for welfare spending, states now receive a block grant that is based on the state's spending between 1992 and 1995 for the former Aid for Families with Dependent Children (AFDC) program. States have a Maintenance of Effort (MOE) requirement that requires them to spend (not appropriate) at least 80 percent of what they spent in their baseline year, with some exceptions. For every dollar that a state falls short, it must forfeit one dollar of the block grant and lose eligibility for other programs. Because states have dramatically reduced welfare rolls, they now have additional funds to expend to address the needs of the "hard-to-serve." A recent national report states that, because few states are considering increasing benefit levels and administrative spending is capped at 15 percent, most of the per family increase is available for new and expanded services. Although some funds may be kept in reserve for "rainy day" needs, states are faced with the dilemma of increasing services or facing penalties and the loss of block grant funds. Caution has to be exerted in the expenditure of these dollars and commitment to fund programs because allocations to all states will be revised in federal fiscal year 2002 and Virginia's block grant will probably be reduced significantly due to the decline in the TANF caseload.

The interim report of the joint subcommittee (HD 77, 1998) stated that "drug addiction affects everyone, either directly or indirectly." Substance abuse is often at the root of crime, family violence, poverty, diminished physical and mental well-being, and lost productivity and income, but research shows that substance addiction is a highly treatable disease. A growing number of national studies confirm that appropriate treatment significantly reduces alcohol and other drug use, improves medical and social functioning, increases earnings through employment, and reduces drug-related crime and the risk of AIDS. Previous legislation was designed to strengthen the state's focus on treatment and emphasize prevention as well as to address a number of criminal justice issues. But treatment for welfare recipients is an immediate concern given the passage of time for benefits. The needs of this particular population of welfare recipients has a certain sense of urgency because they are close to exhausting their benefits and are considered "hard-to-serve" because of their substance abuse problems.

Virginia's welfare reform efforts, coupled with a strong economy, have led to almost a 50 percent reduction of Temporary Assistance to Needy Families (TANF) cases, from 70,797 in June 1995 to 36,662 in June 1999. The "work first" focus of welfare reform has moved many individuals into the competitive labor market and off of welfare. The work component of Virginia's program is "Virginia's initiative for employment, not welfare" (VIEW). Many of the remaining TANF cases are considered "hard-to-serve". What makes someone "hard-to-serve" is not any one characteristic, but includes multiple barriers, including substance abuse, low education and literacy, learning disabilities, borderline mental retardation, mental illness, and victimization of domestic violence. In addition to treatment afforded by CSBs, clients of local departments of social services

often need health, rehabilitation, domestic violence, housing, legal and other services; thus these clients need assistance across the spectrum of human service agencies. This problem is not unique to Virginia. A state-by-state needs assessment conducted in 1998 revealed that meeting the needs of clients with substance abuse problems was among the top three challenges of TANF implementation.

The desired outcomes of the programs developed for this segment of the TANF population include (i) the reduction of welfare and addiction; (ii) the motivation of recipients to participate in treatment; (iii) maintenance of employment by recipients; (iv) receipt of prevention services by children and other family members; and (v) the additional benefit of a reduction of costs associated with health care, Medicaid, foster care, and criminal justice as a result of treatment.

To realize these outcomes, the DMHMRSAS and the Department of Social Services, with the participation of CSBs, developed several long-term objectives which are to:

- Identify and provide appropriate level, intensity, and duration of substance abuse treatment for TANF recipients whose abuse or addiction clearly prevents them from obtaining and retaining work;
- Offer incentives and establish the needed leverage to encourage participants to undergo and complete treatment;
- Offer intensive case management for recipients and their families with multiple problems, including substance abuse;
- Provide specialized employment services integrated with substance abuse treatment;
- Expand existing resources for providing the required levels of treatment; and
- Promote prevention and early intervention for TANF clients and their children.

The strategies necessary to accomplish these objectives are to:

- Provide early identification and treatment on demand that is at the appropriate level, intensity and duration;
- Offer a continuum of services that address all barriers, including specialized employment services;
- Try to treat barriers concurrent with involvement in work to the greatest extent possible;
- Organize treatment around the family, including temporary care of children whose parents require residential care;
- Offer "wraparound" or "one-stop" support services, preferably community based;
- Engage multiple agencies to address all barriers and identify multiple funding streams; and
- Provide incentives to encourage participation in and completion of treatment.

Although accurate assessments of prevalence are difficult, research has shown that one of every five TANF households is headed by an adult with an alcohol or drug

problem. In Virginia, it is estimated that 7,225 TANF clients (at a point in time) may have substance abuse problems, but further work on accurate incidence and data collection needs to be done. These estimates are acknowledged to be difficult to collect because clients may attempt to hide problems because they fear losing custody of their children or prosecution; clients may be in self-denial; and many caseworkers may lack awareness or training about how to identify a drug or alcohol problem or how to address the issues. Thirty-one CSBs responded to a survey indicating that, as of October 1, 1999, they were serving 630 TANF clients. Other Department of Social Services programs are affected by some of these clients as well since substance abuse is suspected to be a key element in the nonpayment of child support by absent parents and is a known factor in child welfare cases and placement of children into foster care.

As a result of collaborative efforts between the Department of Social Services (DSS) and the DMHMRSAS, as well as other agencies of state government, a number of actions to address this population were proposed and implemented. Short-term initiatives include: the expansion of community initiatives and local planning through the provision of information on effective models to address substance abuse problems among TANF recipients; identifying the essential-service components needed in communities to develop an individualized package of services, including screening and evaluation, outpatient care, intensive outpatient or day treatment, integrated and comprehensive case management, short or intermediate residential services, long-term residential, non-medical detoxification, and urine tests; and offering multi-agency training on substance abuse, interviewing, screening and referral skills. Communities could tap currently allocated funds to address, at least partially, substance abuse problems among TANF clients in addition to receiving funds from the $14 million of Welfare-to-Work funds, which were allocated to the Private Industry Councils for serving the "hard-to-serve" populations. Local social services agencies received over $50 million for VIEW services as well, and a portion of those funds may also be used for substance abuse services. A few communities have already funded a substance abuse clinician for their local social services agency. An additional sum of $732,000 was also earmarked in the 1998-2000 biennium for several special projects involving DSS, the DMHMRSAS, and the Department of Rehabilitative Services (DRS) that will establish comprehensive substance abuse and other services in several pilots around the Commonwealth.

In recognition of the importance and priority of addressing substance abuse and dependence across caseloads of many human service agencies, the following efforts are now underway.

- DSS has implemented several administrative policy changes, with others under consideration, that will strengthen the process of identifying and treating substance abuse problems and this work will be ongoing.
- At the state level, DSS, the DMHMRSAS, and DRS deployed several approaches to further the development of local initiatives and planning for substance abuse services, including:

a) Localities received information about effective models in addressing substance abuse among TANF recipients and have had the opportunity for multi-agency training. These efforts will be ongoing through 2001.

b) Several localities received funds and technical assistance to develop or enhance LINK projects for the TANF population that will test and refine various components in the treatment model. Project LINK, the model underlying the VIEW-LINK effort, has been a highly effective collaborative effort administered by community services boards, now in eight localities. This established model provides wrap-around services, as well as in-home counseling and case management to help pregnant, post-partum, and at-risk women overcome substance abuse and dependence, as well as other problems. Collaborative teams at the management and staff levels support an interdisciplinary approach to case management, treatment and other services. While LINK traditionally focused on perinatal women, the VIEW-LINK project will focus on all TANF recipients participating in, or headed for, the VIEW program.

c) Communities received guidance on planning and have had opportunities to seek additional funds, through DSS' Welfare Reform Phase II and competitive Welfare-to-Work funds.

d) DSS has allocated $1.5 million for residential treatment that localities can access as needed for TANF clients and their children. This helps to address a major resource gap and allows residential care to be offered to TANF clients who have the most serious substance abuse problems.

- New programming is underway in many localities, including:

a) Fairfax County has been awarded $338,000 in Welfare to Work funds for a project focused on hard-to-serve TANF clients with serious substance abuse problems, through June 2001. Three substance abuse counselors will provide immediate access for on-site assessment, substance abuse therapy, linkage to community support systems, and assistance with job location and retention. All services will be coordinated through aggressive case management and active partnering with other local agencies and organizations.

b) The Southeastern Virginia Job Training Administration, a private industry council (PIC), has entered into an agreement with each of the five CSBs in its area for the screening of mental health and substance abuse problems and the provision of non-medical services. The funding involved in this project has financed an on-site clinician for Virginia Beach.

c) Many communities are expanding screening, assessment and treatment through the Welfare to Work funds allocated to the PIC's service delivery

area. A number of local agencies are using some of their existing TANF (VIEW) allocations to fund substance abuse services and others are blending funds.

- While the DMHMRSAS' new funding of over $11 million for substance abuse programs serves the general population, its designation of women and dependent children as a priority group should expand treatment resources available to TANF clients. These funds also make possible the expansion of DRS' specialized employment services that should benefit TANF clients as well.
- Expanded services have led to new partnerships at the state level and among Private Industry Councils, local departments of social services, DRS field offices, and CSBs to address substance abuse issues. The DMHMRSAS, DRS, and DSS have also collaborated and developed a multi-agency action plan to address substance abuse issues as part of DSS' approach to addressing the needs of the hard to serve TANF population.

RECOMMENDATION 36: *That the Department of Social Services, the DMHMRSAS, and other affected and participating agencies continue to expand the provision of substance abuse treatment services to TANF recipients, identify funding requirements for future biennia, propose any necessary statutory changes to implement such a program, and provide regular, intensive evaluation of program outcomes to the Governor and General Assembly.*

IV. RELATED ISSUES AND REPORTS

A. Housing

For a system of treatment that is community-based and which has as its ultimate goal the reintegration of an individual to the greatest extent possible, affordable, stable housing is paramount in the array of services and supports which promote recovery and reduce dependence on more costly and restrictive care settings. Severe disabilities restrict the ability to obtain and retain employment, therefore reliance on public assistance, usually Supplemental Security Income (SSI), is a permanent condition. Government, in order to make any housing proposal work, must commit not only to providing the economic incentives to develop the housing itself, but also to the services that will allow clients to maintain their independence and residency.

Funding for capital projects for special needs housing has decreased from all sources as the need in this area has increased. Waiting lists grow longer as funds for the production of affordable rental units decline. The lack of capital for special-needs project development is compounded by the limited cash flow in housing units serving low-income individuals. Project sponsors are generally nonprofit organizations with extensive support service capacity who lack the capital resources to secure project financing on the private market and who need technical assistance to complete complex loan packages that provide lower interest rates or mortgage subsidies. The resurgence in

the demand for special-needs housing points to a need to identify a resource and delivery system to provide for the development of a variety of housing options, including efficiency and single-bedroom apartments and, to a lesser extent, group homes.

Complicating these factors are the general lack of information and a failure to accurately forecast the number of individuals who need residential alternatives, especially with the new direction in the system that emphasizes community residence and treatment. In addition, a large number of persons with disabilities currently reside with aging parents and will soon face the prospect of finding an independent placement. A number of general factors have had an impact on the housing problem, including a limited number of available housing units; a loss of low-income housing during the 1980s; long waiting lists for Section 8 vouchers; a system that has not placed enough emphasis on housing; housing developers that often place low priority on the needs of MH/MR/SA clients; and the fact that disability often coexists with poverty.

1. Residential Services and Housing Supports

It is important to distinguish between residential services and housing supports. Often, these are confused, and this makes addressing the issue of housing more difficult. Residential services may include a housing arrangement. That is, the consumer lives in the place where he receives residential services. However, not all residential services include housing as part of the service. Conversely, many consumers may need a place to live, but they do not require treatment-oriented residential services. In either case, many surveys reveal strong feelings on the part of most consumers to have some control over where they live, a desire we all share.

Most residential services for individuals with mental illness, mental retardation, or substance addiction or abuse problems include a housing component. The *Core Services Taxonomy* published by the DMHMRSAS defines five types of residential services:

- Highly intensive services provide overnight care in conjunction with intensive treatment or training services. Examples include mental health residential alternatives to hospitalization, community intermediate care facilities for persons with mental retardation, and non-hospital-based detoxification programs for people with alcohol or other drug addiction or abuse problems.
- Intensive services provide overnight care in conjunction with treatment or training that is less intense than the first type of residential service. Examples include substance abuse primary care and group homes for individuals with mental illnesses, mental retardation, and substance addiction or abuse problems.
- Supervised services offer overnight care in conjunction with supervision and services. Examples include supervised apartments, domiciliary care (e.g., adult care residences), emergency shelter or residential respite, and sponsored placements (e.g., individualized therapeutic homes, specialized foster care, and family sponsor homes).
- Supportive services support individuals in their own housing arrangements. This does not normally involve overnight care. Examples include in-home respite care

and supported-living arrangements, which assist people to locate or maintain their own housing.

- Family support assists families who choose to provide care at home for family members with mental disabilities, primarily with mental retardation.

The first three types of residential services actually involve providing housing directly, as part of the service. In the other two services, housing is not provided as a part of the service, but, instead, helps individuals or family members to obtain or maintain their own housing arrangements.

In the past, the issue of housing has often been viewed only from the perspective of buying or building housing, such as group homes or apartments. Several initiatives in previous decades have produced some facilities. The Virginia Housing and Development Authority provided some innovative financing through bond financing in the past for homes. Some CSBs have also developed a range of housing options for consumers, particularly in some rural areas where there was limited housing stock. For example, the Eastern Shore CSB developed several facilities using federal Department of Housing and Urban Development (HUD) loans. Also, the Crossroads CSB constructed facilities with Farmers Home Administration or HUD financing. These examples demonstrate that the lack of housing stock has and can be addressed using existing mechanisms and an entrepreneurial spirit.

Compelling information has been offered that the real problem is not a lack of available housing stock but, rather, lack of sufficient income on the part of the consumer. Very low or nonexistent incomes mean they do not have enough money to make security deposits or pay the rent and utilities to move into their own housing. Some residential services, however, such as supportive services, help consumers do this. Experience with the Medicaid Mental Retardation Home and Community-Based Waiver and the individualized services plans used to discharge long-term patients at several state hospitals has revealed no problems in obtaining housing since the income issue is dealt with as part of the plans of care.

This joint subcommittee has concluded that housing for individuals with mental disabilities should be addressed through the following strategies:

RECOMMENDATION 37: *That the DMHMRSAS, through its Comprehensive State Plan, should identify the numbers of individuals who need residential services, by type of population and service intensity, and the number and types of housing arrangements that would be needed to meet those needs, and, in accordance with § 37.1-48.1 of the Code of Virginia, use this information in preparation of its biennium budget submission to the Governor.*

RECOMMENDATION 38: *That the DMHMRSAS should continue and expand the use of individualized services plans, not only for state facility discharges of long term patients and residents, but also for new initiatives funded by the General Assembly.*

RECOMMENDATION 39: *That the DMHMRSAS should expand the use of supportive residential services to assist more consumers to obtain appropriate housing or to upgrade their existing housing arrangements. This might include a special initiative to provide rental subsidies for identified individuals in priority populations, as a part of their individualized services plans.*

RECOMMENDATION 40: *That the General Assembly should encourage the Virginia Housing and Development Authority (VHDA) to work closely with the DMHMRSAS to increase the flexibility of VHDA's loan programs, to make it easier for housing providers to make more housing available for mentally disabled populations.*

RECOMMENDATION 41: *That the General Assembly should encourage the Department of Housing and Community Development to work closely with the DMHMRSAS to identify and make available resources for increased low-income housing that could be occupied by persons with mental disabilities.*

RECOMMENDATION 42: *At this time, a capital fund to support the construction or acquisition of housing should not be established. Once the preceding recommendations are implemented fully, the need for additional housing stock could be re-examined if necessary.*

2. Adult Care Residences

Adult Care Residences (ACRs) have served as an important housing resource for adults with mental disabilities and will probably expand as a resource as more individuals are discharged from facilities or are diverted from institutional treatment to be cared for in their communities. Recent information indicates that the care of 4,800 persons in adult- care residences who have a diagnosis of mental illness, mental retardation or other neurologically-related disorders is being paid for by public funds, namely auxiliary grants.

The Joint Legislative Audit and Review Commission and this joint subcommittee made a number of recommendations designed to improve services, standards, enforcement, and payment mechanisms. In addition, as a result of the tendency of many clients to gravitate to ACRs that are in proximity to state institutions or facilities, the joint subcommittee, in 1998, directed the Department of Social Services, which licenses ACRs, and the DMHMRSAS to develop pilot projects in areas that have high concentrations of ACRs. The 1998 Session of the General Assembly appropriated $750,000 for each year of the biennium to establish pilot projects for ACR clients with mental disabilities or substance abuse problems served by the Highlands CSB and the Richmond Behavioral Health Authority. (ACRs in the Petersburg and Roanoake areas were added to the pilot project at a later date so results are not available at this time.) The target population was limited to 80 in each site to allow for adequate evaluation and follow-up. Participants received a variety of services and contacts between the CSBs (BHAs) and clients increased dramatically. In addition to clients receiving services, the

ACR staff received a substantial amount of training in recognizing and dealing with the effects of mental health problems.

Evaluation of initial outcomes has been positive and include fewer hospitalizations, less involvement with the criminal justice system, increased involvement in community and therapeutic activities, and improved level of functioning and quality of life. Projected costs per participant are an average of $4,154 per year, including some Medicaid-generated revenue. The pilots will continue through the next year in order to capture data from the expanded pilot project and to examine several issues which have surfaced that might be disincentives to the success of the project, including (i) the effect of employment income and disincentives to work; (ii) economic disincentives for ACR operators to foster functional improvement in residents; and (iii) while Medicaid funds training in or reinforcement of functional skills and appropriate behavior related to health and safety, activities of daily living, and use of community resources for other clients, it does not cover ACR residents.

RECOMMENDATION 43: *That the ACR pilot projects continue to collect and evaluate outcome information and make recommendations back to the General Assembly regarding the possible expansion of such programs. CSBs are also encouraged to use funding, including Medicaid, to leverage funds to seek out and serve those eligible residents who have either been uninvolved or only marginally involved with services.*

During the course of recent events in the Commonwealth, a safety issue has come to light. Although the Department of Social Services, in its licensing process, must be assured that each ACR has a disaster plan, it appears that those plans are not being adequately scrutinized. Issues such as the physical transport of patients in the event of an emergency; transfer of vital medical records, including family or other contact information for a fragile population; and the transfer of medical supplies and drugs to support these individuals need to be addressed and evaluated.

RECOMMENDATION 44: *That the DSS revise its regulations regarding the licensing of adult care residences, regardless of size and population, to require not only a disaster plan but also evaluate such plan for its logistical determination for the relocation of patients, records, medication and other information vital to the safety and well-being of its clients in the event of an emergency.*

B. Brain Injury

It is estimated that nearly 2,000 of the 10,000 people reported to the Virginia Brain Injury Central Registry each year will require long-term services and supports due to resulting physical, cognitive, and behavioral impairments. The majority of persons who survive mild to moderate brain injury are able to return to their homes and families with minimal follow-up support. Some people who sustain a brain injury require intensive specialized treatment and long-term intervention and supports to effectively address cognitive and behavioral challenges directly related to the injury. In the absence of appropriate long-term treatment and support, many people with brain injuries,

especially those with challenging behaviors caused by the injury, are placed in state psychiatric facilities.

In fiscal year 1998, there were 118 individuals with a diagnosis of acquired brain injury, including trauma, dementia, tumor, stroke, and other neurological disease, who resided in Virginia's state psychiatric facilities (this is the unduplicated count of all individuals with this diagnosis who were on inpatient status at any point during that fiscal year). An analysis of patients with a diagnosis of brain injury at Western State Hospital, where the majority of these patients were treated, revealed that almost 20 percent had a primary diagnosis of brain injury with no mental illness or mixed diagnoses of mental illness and neurological head injury, the latter of which significantly impacted clinical presentation. This population is not appropriate for psychiatric hospitalization and would best be served by programs specifically designed to serve individuals with brain injury.

There is limited state funding for specialized services for individuals with brain injury. While DRS provides and administers several critical services and programs for this population, these services are inadequate to meet demand and do not reflect the full continuum of services and supports required for individuals with brain injury and severely challenging behavior. Long-term residential services represent the area of greatest need in Virginia, specifically long-term support living option with intensive behavioral supports. Few providers in Virginia offer affordable short-term behavioral treatment and support within a secure environment for people with brain injury, and none offer long-term services that are affordable to the target group as a whole.

The Woodrow Wilson Rehabilitation Center's Brain Injury Services program is not designed to provide a full continuum of behavioral services and current admission criteria exclude individuals with severely challenging behaviors. The absence of an appropriate, secure residential setting for people with brain injuries and severely challenging behavior forces some individuals requiring intensive behavioral and cognitive retraining to seek such services outside Virginia, sometimes paid for with state dollars.

There is currently no system of care in the community for people with brain injuries and no mental illness. Both short and long-term specialized rehabilitation services for people with brain injuries and severely challenging behavior are needed to divert people from admission to state mental hospitals and to assist individuals in transitioning from state mental health facilities to their communities. The Department of Rehabilitative Services (DRS) is the designated state agency responsible for coordinating rehabilitative services for persons with functional and central nervous system disabilities. Given the limited available funding for specialized services for individuals with brain injury, there is not a comprehensive service delivery system in the Commonwealth to meet the specialized needs of this population. Federal regulations governing Medicaid, however, contain provisions that allow states to provide certain non-medical services by applying for and implementing a Home and Community Based Services Waiver. Fifteen states have implemented such a waiver under Medicaid for persons with brain injury to cover a range of non-medical services, such as case management, structured-day

programming and supported-living services. Such services can assist individuals with brain injury and challenging behavior to avoid institutional care.

The joint subcommittee recommended that the DMHMRSAS and DRS develop an action plan for the appropriate treatment of persons with brain injuries who also have mental illness (Senate Joint Resolution 158, 1998). Their recommendations in Senate Document 16, 1999, include:

- The DMHMRSAS should continue to admit and treat people with a primary mental illness diagnosis and a co-occurring head injury that presents no significant clinical concerns.
- For people with a primary mental illness diagnosis and a co-occurring head injury that is a significant clinical factor in their treatment, Western State Hospital and Woodrow Wilson Rehabilitation Center's Brain Injury Services Program should establish a model pilot program of consultation and staff cross-training to ensure more comprehensive treatment of the co-occurring disorders in the psychiatric setting.
- The Commonwealth, through DRS in collaboration with the DMHMRSAS, should support the development of community-based models for the provision of services to persons with brain injuries and challenging behaviors.
- The Commonwealth should develop secure residential programs for short-term and long-term treatment and rehabilitation of individuals with the most severely challenging behaviors.
- The Commonwealth should develop long-term supported living options that will assist individuals with brain injuries to live in their own homes.
- DRS and the DMAS should pursue financing for residential services through a Medicaid waiver for home-and-community-based services targeted to Virginians with brain injury.
- DRS, in collaboration with DMAS, should study the use of dedicated brain-injury units in nursing facilities, and explore strategies to expand these services where feasible and appropriate.

C. Employment Services

The Virginia Department of Labor and Industry reports that the 1997 annualized rate of unemployment in Virginia for the civilian work force was 4 percent; however, unemployment rates for people with mental disabilities are significantly higher. The DMHMRSAS 1995 *Continuum of Care Study: An Assessment of Service Needs Within the Public System of Mental Health, Mental Retardation and Substance Abuse Services*, reported that most CSB mental health clients (85%), most mental retardation clients (62%), and many substance abuse clients (55%) were either unemployed or not in the labor force. These unemployment rates and the lack of jobs for people with mental disabilities are major barriers to successful recovery, community integration, and financial independence.

In fiscal year 1997, employment services were provided by 16 (40%) of CSBs to 836 (2%) mental health clients by 24 (1%) CSB staff with $2.1 million (1%) in expenditures; similarly, 32 (80%) CSBs provided employment services to 18,887 (23%) clients with mental retardation, using 280 (10%) staff and $28 million (19%) in funds. CSBs does not offer employment services for clients with substance abuse problems. A recent California study noted that provision of vocation rehabilitation to individuals with mental disabilities had three positive outcomes: increased taxes paid, reduced public assistance, and reduced mental health costs. A study by DRS and the DMHMRSAS, recommended by the joint subcommittee (Senate Joint Resolution 151, 1998) resulted in a number of recommendations that were reported in Senate Document 14, 1999, including that:

- The DMHMRSAS and DRS should continue to work together to address the employability needs of adults with a serious mental illness by enhancing and expanding upon current joint activities.
- That the DMHMRSAS and DRS should adopt and implement financial incentives and funding with strategies that promote the expansion of cost effective employment options for people with mental disabilities.
- That the DMHMRSAS, DRS and a representative from the Social Security Administration should closely monitor the pending federal legislation and the results and pending recommendations of pending studies on employment services for people with mental disabilities.
- That the DMHMRSAS should evaluate the outcomes of consumer-operated employment programs and determine the cost effectiveness of expansion.
- That the DMHMRSAS should study existing psychosocial rehabilitation programs in Virginia to determine the nature, extent, and effectiveness of vocational services and supports provided in these programs.
- Staff should follow the outcome of federal legislation (H.R. 1180, Ticket to Self-Sufficiency Act), P.L. 106-170 that would provide a "ticket to work" for individuals with disabilities.
- A funding request should be developed based on the Virginia state team of the President's Committee on Mental Retardation, to "make a job or vocation/day program available to every individual who wants one in Virginia."
- DRS and the DMHMRSAS should be funded to implement a coordinated statewide database and outcome measures that would collect consistent information on (i) the number of individuals working in each disability area: (ii) the number of hours worked each week; (iii) hourly wages; (iv) benefits (if any); (v) funding sources utilized for training/support functions and for how long utilized; and (vi) length of employment.
- A private/public interagency group made up of businesses, family members, individuals with mental retardation, state and local funding agencies, advocates, and private providers of services should be formed and funded to examine employment systems change, public awareness, training and education, data system components, and funding streams for increasing access to integrated employment.

- Portions of state block-grant funds could be redirected to prioritize employment for individuals with disabilities in a cost-effective program initiative.
- Recommendations from the study of employment options, policies and funding streams currently available to Virginians with developmental disabilities, that was conducted by the VCU Rehabilitation Research Training Center with a small grant from the Virginia Board for People with Disabilities, should be reviewed.
- The DMHMRSAS and DRS should expand specialized vocational rehabilitation services for persons with substance-abuse disabilities to the remaining 37 CSBs without such services.
- The DMHMRSAS should provide training to DRS counselors on how to identify substance abuse disabilities in clients.
- CSBs should allow DRS counselors to participate as full partners on the treatment teams at the CSBs and in all treatment facilities.
- DRS and CSBs should provide for onsite job-seeking and job-keeping skills training activities at treatment facilities.
- DRS and CSBs should provide for team building, cross training and education for DRS and CSB staff involved in substance abuse services.
- DRS and the DMHMRSAS should enhance collaboration between program coordinators in order to improve technical assistance and quality assurance.

D. Primary Health Care Needs of the Mentally Disabled

Having heard much testimony about the unique health problems and difficulties in accessing care, either because of inadequate insurance coverage or the dearth of specialists in these areas; and since adverse health incidents can have a devastating effect on those with disabilities, the joint subcommittee recommended that the Department of Health (Senate Joint Resolution 154, 1998) conduct a study on the primary health care needs of those persons with mental illness, mental retardation and substance abuse problems. A review of relevant literature and other states' experiences showed that persons with mental illness, mental retardation and substance abuse addiction or dependence are more likely to suffer physical illness and are more likely to die prematurely than the general population. It was also noted that access to needed health care presents particular problems.

Beyond deaths due to unnatural causes, such as suicide and homicide, among psychiatric patients, premature death is still likely. One in five psychiatric patients has a co-occurring medical condition causing or exacerbating the psychiatric condition. In a study of mortality among community mental health center outpatients, the mortality rate of the outpatients was 4.4 times higher than that of the general population for unnatural causes and 70 percent higher from natural causes. In contrast, another study showed that only 47 percent of the active, important physical diseases had been recognized by the mental health system and six percent of the study patients were judged to have a physical illness that caused the mental disorder.[7]

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[7] *Assessment of the Primary Health Care Needs of Persons with Mental Illness, Mental Retardation and Substance Abuse Problems*, Report of the Department of Health, January, 1999.

According to research, mental retardation is a physical condition that exists, which is severe enough to compromise a person's intellect. Retardation is also a medical condition that can be avoided to some degree through prevention efforts. Most persons with mental retardation have chronic medical conditions that require ongoing medical intervention and access to specialized care. Life expectancy is traditionally inversely related to the severity of mental retardation, but studies show that mortality and morbidity in persons with mental retardation can be reduced with improvements in health care delivery and improved record keeping, emphasis on developmental disabilities in primary care training, and coordination of health care services with social services. Access to care is a particular problem for persons with mental retardation. Barriers include system barriers, such as fragmentation in the health care delivery system; consumer barriers, such as inability to communicate needs and the complexity of medical conditions; provider barriers, such as negative attitudes and uneven distribution of physicians; and barriers involving direct-care staff who are inadequately trained and burdened by excessive paperwork.

Medical complications from substance abuse are commonplace. Abuse leads to medical conditions that require higher levels of care for abusers than the general population. There are at least 72 medical conditions requiring hospitalizations that are wholly or partially attributable to substance abuse. Secondary medical conditions fall into two categories: (i) nutritional and (ii) diseases caused by the direct toxic effects of alcohol. Evidence shows that over 100,000 persons die each year as a result of alcohol and drug abuse, and AIDS deaths account for another 12,000 deaths.

In response to this review, the Department of Health made the following recommendations, which are endorsed by the joint subcommittee.

RECOMMENDATION 45: *That, in order to enhance the system of primary health care for persons with mental illness, mental retardation and substance abuse services, the Department of Health should pursue the following objectives:*

- *To review medical capacity in CSBs, medical/surgical care in facilities and medical clearance for admission to state facilities. Assessment of the primary health care status of CSB and facility patients should be systematic and routine.*
- *To solicit funding to further examine the actual gaps in primary health service delivery to the mental ill, mentally retarded and substance abuse population. This would involve the use of a consultant.*
- *To study additional ways of assuring proper primary health care assessment of persons with mental health, mental retardation, or substance abuse problems that require emergency hospitalization.*
- *To incorporate more training on treating those with mental illness, mental retardation and substance abuse problems into the curriculum of medical students.*

V. WHAT THE FUTURE HOLDS

Much has been accomplished, but much still remains to be done to achieve the vision of an effective, consumer-focused system of publicly funded mental health, mental retardation and substance abuse services in the Commonwealth. This vision will undoubtedly be affected not only by our hopes for the future but also by outside influences, namely federal legislation, enforcement and judicial interpretations.

A. *Olmstead et al. v. L.C. et al.*

The U.S. Supreme Court decision in *Olmstead et al. v. L.C. et al.*, 527 U.S. 581, 119 S.Ct 2176 (1999) affirmed that persons with disabilities who are left to languish in institutions may have suffered discrimination under the federal Americans With Disabilities Act (ADA) by being unjustifiably deprived of an opportunity to live in the community, yet it leaves open the question of a state's responsibility to provide community-based services for persons with disabilities.

In enacting the ADA, Congress determined that "society has tended to isolate and segregate individuals with disabilities," and "discrimination against individuals with disabilities persists in such critical areas as...institutionalization." 42 U.S.C. §§ 12101(a)(2), (3) (5) (1999), *Olmstead*, 119 S.Ct. 2176, at 2181, n. 1. Title II of the ADA prohibits discrimination in public services furnished by governmental entities and the implementing regulations issued by the Attorney General include the "integration regulation" which states: "A public entity shall administer services, programs and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d) (1998), *Olmstead*, 119 S.Ct. 2176, at 2183. Another regulation requires public entities to "make reasonable modifications...to avoid discrimination on the basis of disability," unless those modifications would entail a "fundamenta[l] alter[ation]." 28 C.F.R. § 35.130 (b)(7) (1998), *Olmstead*, 119 S.Ct. 2176, at 2183.

In *Olmstead,* the respondents, Lois Curtis (L.C.) and Elaine Wilson (E.W.) are persons with mental retardation who resided in a state mental hospital and sued Georgia for placement in community-based care in Atlanta. They each had been approved by treating professionals for community-based care, but faced long waiting lists. In May 1995, L.C. filed suit under 42 U.S.C. 1983 and provisions of the ADA challenging her confinement in a segregated environment and E. W. intervened. The District Court granted partial summary judgment in favor of L.C. and E.W., claiming that Georgia's failure to place them in an appropriate community-based treatment program violated Title II of the ADA. The court rejected Georgia's argument that inadequate funding, not discrimination, accounted for their continued confinement in that "unnecessary institutional segregation of the disabled constitutes discrimination per se, which cannot be justified by a lack of funding." *Olmstead*, 119 S.Ct. at 2184. Georgia argued that court-ordered immediate transfers would "fundamentally alter" their program, yet the court observed that existing state programs could "provide services to plaintiffs in the

community at considerably less cost than is required to maintain them in an institution." *Olmstead*, 119 S.Ct. 2184.

The Court of Appeals for the Eleventh Circuit affirmed the judgment of the District Court, but remanded for reassessment of the state's cost-based defense. *Olmstead et al. v. LC et al.*, 138 F.3d 893 at 905 (1998). While the Court of Appeals recognized that the state's duty to provide integrated services "is not absolute," under the Attorney General's Title II regulation, "reasonable modifications" were required, but fundamental alterations were not demanded. *Olmstead*, 119 S.Ct. at 2184 (citing *Olmstead*, 138 F.3d at 904)). The Court of Appeals remanded requesting the District Court to consider "whether additional expenditures necessary to treat L.C. and E.W. in community-based care would be unreasonable given the demands of the state's mental health budget." *Olmstead*, 119 S.Ct. at 2185 (citing *Olmstead*, 138 F.3d at 905).

On June 22, 1999, Justice Ginsberg, writing for the majority, noted:

> This case concerns the proper construction of the anti-discrimination provision contained in the public services portion (Title II) of the Americans with Disabilities Act of 1990.[...] Specifically, we confront the question whether the proscription of discrimination may require placement of persons with mental disabilities in community settings rather than in institutions. The answer, we hold, is a qualified yes. *Olmstead*, 119 S.Ct. at 2181.
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> [U]nder Title II of the ADA, states are required to provide community-based treatment for persons with mental disabilities "when the State's treatment professionals determine that such placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities." *Olmstead*, 119 S.Ct. at 2181.
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> In affirming the Court of Appeals decision, the Court held: "Unjustified isolation [...] is properly regarded as discrimination based on disability. But we recognize, as well, the States' need to maintain a range of facilities for the care and treatment of persons with diverse mental disabilities, and the States' obligation to administer services with an even hand. Accordingly, we further hold that the Court of Appeals' remand instruction was unduly restrictive. In evaluating a State's fundamental-alteration defense, the District Court must consider, in view of the resources available to the State, not only the cost of providing community-based care to the litigants, but also the range of services the State provides others with mental disabilities, and the State's obligation to mete out those services equitably." *Olmstead*, 119 S.Ct. at 2185. The Supreme Court

remanded the case for further proceedings consistent with the opinion. *Olmstead*, 119 S.Ct. at 2190.

In other words, while the Supreme Court has stated that segregation of individuals with disabilities in institutions may constitute discrimination, the Supreme Court held that the lower courts erroneously evaluated Georgia's fundamental alteration defense (i.e., the claim that providing community-based services to an individual would fundamentally alter the state's service delivery system) by only looking to what the cost of community care is in relation to the entire state budget. Such a review does not adequately capture or adequately test the state's obligation to administer services with an even hand.[8] If Georgia can now demonstrate on remand that immediate relief for plaintiffs would be inequitable given the state's diverse service-delivery system for persons with mental disabilities, it will meet the fundamental alteration defense contemplated by the ADA regulations.[9] If Georgia fails in its defense, L.C. and E.W. will prevail on their ADA discrimination claim.

This decision, therefore, provides a minimal standard for a state system of institutional and community facilities and services that could withstand ADA challenge, i.e., "a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace,"[10] but leaves open-ended the meaning of "reasonable pace" for community treatment, as well as what services are necessary to ensure adequate treatment in the community.

B. The Impact of *Olmstead* on Virginia

The *Olmstead* decision appears to ratify the work of the joint subcommittee that, for the last four years, has facilitated the ADA integration mandate. The Commonwealth has been moving in the direction of providing more services for persons with disabilities in community-based settings. In 1998, the General Assembly passed House Bill 428, upon the recommendation of the joint subcommittee, in order to facilitate implementation strategies for placing qualified persons with mental disabilities residing in state facilities, or who were at-risk of placement, in less restrictive settings. House Bill 428 provided the framework for addressing the requirements in the *Olmstead* decision. The legislation

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[8] The Supreme Court states, "the State's responsibility, once it provides community-based treatment to qualified persons with disabilities, is not boundless." *Olmstead*, 119 S.Ct. at 2188.

[9] The Supreme Court held that a proper interpretation of "the fundamental alteration component of reasonable-modifications regulations would allow the State to show that, in the allocation of available resources, immediate relief for the plaintiffs would be inequitable, given the responsibility the state has undertaken for the care and treatment of a large and diverse population of persons with mental disabilities." *Olmstead*, 119 S.Ct. at 2189.

[10] As an example of meeting the reasonable-modifications standard, the Supreme Court held a state could "demonstrate that it had a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated.... In such circumstances, a court would have no warrant effectively to order displacement of persons at the top of the community-based treatment waiting list by individuals lower down who commenced civil actions." *Olmstead*, 119 S.Ct. at 2189-2190.

required the DMHMRSAS to develop a Comprehensive State Plan that "shall identify the needs of and the resource requirements for providing services and supports to persons with mental illness, mental retardation or alcohol or other drug abuse problems or dependence across the Commonwealth and shall propose strategies to address these needs." In addition, the bill required community services boards to provide predischarge planning for any person who is to be released from a state mental health facility or training center back into the community.

During the 1998 and 1999 sessions, the General Assembly appropriated a record increase of $171 million in new general funds to strengthen the system of care for mentally disabled persons in Virginia. More that $100 million of these funds were targeted at serving mentally disabled persons in the community. In addition, the joint subcommittee has publicly committed to the need for additional funds that will provide adequate services to all those persons identified to be in need of services.

C. Joint Commission on Behavioral Health Care

As the public system of mental health, mental retardation and substance abuse services grows and serves more persons in need, so do the inevitable problems associated with service philosophy and adequacy of funding. Over the past 35 years, the Commonwealth has waxed and waned in its attention to the needs of people with mental disabilities, usually peaking its attention when problems grow to such proportions that studies or "quick fixes" are necessary. Much commendable work has been accomplished by such legislative studies such as the Hirst Commission, the Bagley Commission, the Emick Commission, and, of course, by the ongoing work of this joint subcommittee. But, the needs of people with mental disabilities require a more consistent level of attention. People with mental disabilities often cannot speak for themselves and must depend upon their families and associates to speak on their behalf. As the system evolves, continuous oversight and evaluation by the General Assembly will be necessary to ensure that the needs of people with mental disabilities receive the highest priority consideration.

In 1998, the General Assembly passed legislation creating the Joint Commission on Behavioral Health Care, on the recommendation of the joint subcommittee. Similar to the Joint Commission on Health Care, it would study, report, and make recommendations on all areas of behavioral health care service delivery, financing and regulation on a permanent basis. The Governor vetoed the bill because, among other things, the Commission was believed to duplicate the responsibilities of the Executive Branch and the joint subcommittee, which was being continued for two years. Two years later, the joint subcommittee is not being continued, but oversight and further study would assist the General Assembly in determining the future course for the provision of vital services. A Joint Commission on Health Care would provide a forum for public comment and deliberation to ensure that services are appropriate and needs are addressed.

RECOMMENDATION 46: *That the General Assembly create a legislative agency known as the Joint Commission on Behavioral Health Care, similar to the Joint Commission on Health Care, to provide oversight and attention to the needs of those persons needing mental health, mental retardation and substance abuse services and their families. The membership would be comprised of legislative members and citizens of the Commonwealth who would serve for set terms. The duties of the Commission would include the examination of state agency responsibilities; identification of innovations in other states and the private sector that can serve as models for Virginia; review and analysis of up-to-date research; and providing advice and assistance to the Commonwealth.*

VI. Appendices

1. **House Joint Resolution 225**
2. **Chapter 680, 1998 Acts of Assembly (House Bill 428)**
3. **Status of House Document 77 (1998) Recommendations**
4. **Options for Structure and Administration**
5. **Alternative Model III**
6. **Chapter 969, 1999 Acts of Assembly--Reconvened Session (Senate Bill 1224)**
7. **Listing of HJR 225 Joint Subcommittee Recommendations**
8. **2000 Session Legislation**

APPENDIX VI-1

ENROLLED

HOUSE JOINT RESOLUTION NO. 225

Continuing the Joint Subcommittee Evaluating the Future Delivery of Publicly Funded Mental Health, Mental Retardation and Substance Abuse Services.

Agreed to by the House of Delegates, March 12, 1998
Agreed to by the Senate, March 10, 1998

WHEREAS, the Joint Subcommittee Evaluating the Future Delivery of Publicly Funded Mental Health, Mental Retardation and Substance Abuse Services was established by House Joint Resolution No. 240 (1996); and

WHEREAS, the resolution directed the joint subcommittee to examine (i) the current services system, (ii) the principles and goals of a comprehensive publicly funded system, (iii) the range of services and eligibility for those services, (iv) the methods of funding publicly supported community and facility services, (v) the relationship between the Department of Mental Health, Mental Retardation and Substance Abuse Services and the components of the service system, (vi) the information and technology needs to provide appropriate and enhanced accountability, (vii) changes needed in the Code of Virginia, (viii) ways to effectively involve consumers and families in planning and evaluating the publicly funded system, and (ix) recommendations of previous studies and the work of the Secretary of Health and Human Resources' Task Force; and

WHEREAS, the joint subcommittee has made recommendations to effect sweeping changes in the delivery of publicly funded services; and

WHEREAS, while numerous recommendations have been made, the joint subcommittee believes that many issues still need to be resolved and oversight is needed for the implementation of current recommendations; and

WHEREAS, the joint subcommittee identified two particular issues that will require review and resolution; and

WHEREAS, the first of these issues is determining the most effective structure and location of an external human rights protection system in Virginia, to which increased attention has been brought by the serious incidents and deaths in state mental health and mental retardation facilities; and

WHEREAS, two human rights programs now operate to protect consumers: the program operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services, commonly known as the "internal" system since the Department also provides services to some of the same persons protected by its system; and the program operated by the Department for the Rights of Virginians with Disabilities under the federal Protection and Advocacy for Individuals with Mental Illness (PAIMI) Act and the Developmental Disabilities Assistance and Bill of Rights (DD) Act; and

WHEREAS, there is a perception that more needs to be done to (i) ensure complete independence of any external human rights system from the internal system, (ii) complement but not duplicate the internal system, (iii) ensure that the system is supported by adequate levels of resources, (iv) increase consumer access, (v) increase oversight responsibility, and (vi) ensure that the system is objective; and

WHEREAS, recommendations in a 1997 State Board of Mental Health, Mental Retardation and Substance Abuse Services report on human rights called for further study; and

WHEREAS, a second issue involves the need to study welfare reform and substance abuse policy, since public assistance recipients often experience a wide range of employment barriers, including the abuse of alcohol and other drugs; and

WHEREAS, a 1995 study by the U.S. Department of Health and Human Services concluded that substance abuse affected the ability of more than 15 percent of welfare recipients to find and maintain employment; and

WHEREAS, an integrated welfare reform and substance abuse policy will need to address issues concerning assessment, treatment capacity, funding, data collection and analysis, interagency coordination, work and treatment coordination, staff training, and outcome measurement; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Subcommittee Evaluating the Future Delivery of Publicly Funded Mental Health, Mental Retardation and Substance Abuse Services be continued. The total membership of the joint subcommittee shall be 17 members

and shall include 4 new members as provided for in this resolution. The members duly appointed pursuant to HJR No. 240 (1996) shall continue to serve. Any vacancies shall be filled as provided in the enabling resolution, except that appointments of the members of the House of Delegates to fill vacancies shall also be in accordance with the principles of Rule 16 of the House Rules. The four additional members of the joint subcommittee shall be appointed as follows: one member and one former member of the House of Delegates to be appointed by the Speaker of the House in accordance with the principles of Rule 16 of the House Rules; and one member and one former member of the Senate to be appointed by the Senate Committee on Privileges and Elections.

The direct costs of this study shall not exceed $28,050.

An estimated $50,000 is allocated for consulting services. Such expenses shall be funded by a separate appropriation from the General Assembly.

The Division of Legislative Services shall provide staff support for the study. All agencies of the Commonwealth shall provide assistance to the joint subcommittee, upon request.

The joint subcommittee shall complete its work in time to submit its findings and recommendations to the Governor and the 2000 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

Implementation of this resolution is subject to subsequent approval and certification by the Joint Rules Committee. The Committee may withhold expenditures or delay the period for the conduct of the study.

APPENDIX VI-2

CHAPTER 680

An Act to amend and reenact §§ 37.1-98, 37.1-194 through 37.1-199, 37.1-202.1, 37.1-242, 37.1-243, 37.1-245 through 37.1-248, and 37.1-250 through 37.1-253 of the Code of Virginia and to amend the Code of Virginia by adding in Article 2 of Chapter 1 of Title 37.1 a section numbered 37.1-48.1 and by adding sections numbered 37.1-194.1 and 37.1-248.1, relating to community mental health, mental retardation and substance abuse services; behavioral health authorities; Comprehensive State Plan.

[H 428]

Approved April 16, 1998

Be it enacted by the General Assembly of Virginia:

1. That §§ 37.1-98, 37.1-194 through 37.1-199, 37.1-202.1, 37.1-242, 37.1-243, 37.1-245 through 37.1-248, and 37.1-250 through 37.1-253 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding in Article 2 of Chapter 1 of Title 37.1 a section numbered 37.1-48.1 and by adding sections numbered 37.1-194.1 and 37.1-248.1 as follows:

§ 37.1-48.1. Comprehensive State Plan for mental health, mental retardation and substance abuse services.

The Department, in consultation with community services boards, behavioral health authorities and state mental health and mental retardation facilities and with consumers, consumers' families, advocacy organizations, and other interested parties, shall develop and update biennially a six-year Comprehensive State Plan for mental health, mental retardation and substance abuse services. The Comprehensive State Plan shall identify the needs of and the resource requirements for providing services and supports to persons with mental illness, mental retardation or alcohol or other drug abuse problems or dependence across the Commonwealth and shall propose strategies to address these needs. The Comprehensive State Plan shall be used in the development of the Department's biennial budget submission to the Governor.

§ 37.1-98. Discharge, conditional release, and convalescent status of patients.

A. The director of a state hospital may discharge any patient after the preparation of a predischarge plan formulated in ~~cooperation~~ *accordance* with *the provisions of § 37.1-197.1 by* the community services board which serves the political subdivision where the patient resided prior to hospitalization or with the board located within the political subdivision the patient chooses to reside in immediately following the discharge, except one held upon an order of a court or judge for a criminal proceeding, as follows:

1. Any patient who, in his judgment, is recovered.

2. Any patient who, in his opinion, is not mentally ill.

3. Any patient who is impaired or not recovered and whose discharge, in the judgment of the director, will not be detrimental to the public welfare, or injurious to the patient.

4. Any patient who is not a proper case for treatment within the purview of this chapter.

~~The predischarge plan required by this paragraph shall, at a minimum, (i) specify the services required by the released patient in the community to meet the individual's needs for treatment, housing, nutrition, physical care and safety; (ii) specify any income subsidies for which the individual is eligible; (iii) identify all local and state agencies which will be involved in providing treatment and support to the individual; and (iv) specify services which would be appropriate for the individual's treatment and support in the community but which are currently unavailable.~~ For all individuals discharged on or after January 1, 1987, the predischarge plan shall be contained in a uniform discharge document developed by the Department and used by all state hospitals. If the individual will be housed in an adult care residence, as defined in § 63.1-172, the plan shall so state.

B. The director may grant convalescent status to a patient in accordance with rules prescribed by the Board. The state hospital granting a convalescent status to a patient shall not be liable for his expenses during such period. Such liability shall devolve upon the relative, committee, person to whose care the patient is entrusted while on convalescent status, or the appropriate local public welfare agency of the county or city of which the patient was a resident at the time of admission. The

provision of social services to the patient shall be the responsibility of the appropriate local public welfare agency as determined by policy approved by the State Board of Social Services.

C. Any patient who is discharged pursuant to subdivision A 4 hereof shall, if necessary for his welfare, be received and cared for by the appropriate local public welfare agency. The provision of social services to the patient shall be the responsibility of the appropriate local public welfare agency as determined by policy approved by the State Board of Social Services. Expenses incurred by the provision of public assistance to the patient, who is receiving twenty-four-hour care while in an adult care residence licensed pursuant to Chapter 9 (§ 63.1-172 et seq.) of Title 63.1, shall be the responsibility of the appropriate local public welfare agency of the county or city of which the patient was a resident at the time of admission.

§ 37.1-194. Purpose; services to be provided.

The Department, for the purposes of establishing, maintaining, and promoting the development of mental health, mental retardation and substance abuse services in the Commonwealth, may ~~make matching grants~~ *provide funds* to assist any *city or* county ~~having a population of approximately 50,000 or more or any city having a population of approximately 75,000 or more~~, or any combination of political subdivisions ~~having a combined population of approximately 50,000 or more, or any city or county or combination thereof which has less than the above prescribed populations which the Department determines is in need of such services~~, in the ~~establishment and operation of local mental health, mental retardation and substance abuse programs~~ *provision of such services.* Every county ~~and~~ *or* city ~~shall establish, either singly or in combination with another political subdivision, a~~ *or combination of cities or counties or counties and cities shall establish a community services board. Every county or city or combination of cities or counties or cities and counties that has established a community services board shall, in consultation with its community services board, designate its board as an operating* community services board, *an administrative policy community services board or a local government department with a policy-advisory community services board ~~on or before July 1, 1983~~. The governing body or bodies of the political subdivision or subdivisions that established the community services board may change this designation at any time by ordinance. In the case of a community services board established by more than one political subdivision, the decision to change this designation shall be unanimous.*

The core of ~~program~~ services to be provided by *operating* community services boards, *administrative policy community services boards or local government departments with policy-advisory community services boards* within the political subdivisions *that* they serve shall include emergency services, *and case management services subject to such funds as may be appropriated therefor,* and may include *a comprehensive system of* inpatient ~~services~~, outpatient, ~~and~~ day-support ~~services~~, residential ~~services~~, prevention ~~and~~, early intervention ~~services~~, and other appropriate mental health, mental retardation and substance abuse ~~programs~~ *services* necessary to provide ~~a comprehensive system of~~ *individualized* services *and supports to persons with mental illnesses, mental retardation, or alcohol or other drug abuse problems or dependence.*

§ 37.1-194.1. Definitions.

As used in this title, unless a different meaning clearly appears from the context:

"Administrative policy community services board" or "administrative policy board" means the public body organized in accordance with the provisions of this chapter that is appointed by and accountable to the local governing body of each political subdivision that established it to set policy for and administer the provision of mental health, mental retardation and substance abuse services. The "administrative policy community services board" or "administrative policy board" denotes the board, the members of which are appointed pursuant to § 37.1-195 with the powers and duties enumerated in §§ 37.1-197 B and 37.1-197.1. Mental health, mental retardation and substance abuse services are provided through local government staff, or through contracts with other organizations and providers.

"Operating community services board" or "operating board" means the public body organized in accordance with the provisions of this chapter that is appointed by and accountable to the local governing body of each political subdivision that established it for the direct provision of mental health, mental retardation and substance abuse services. The "operating community services board" or "operating board" denotes the board, the members of which are appointed pursuant § 37.1-195

with the powers and duties enumerated in §§ 37.1-197 A and 37.1-197.1. "Operating community services board" or "operating board" also includes the organization that provides such services, through its own staff or through contracts with other providers, unless the specific context indicates otherwise.

"Performance contract" means the annual agreement negotiated by an operating community services board, an administrative policy community services board, or a local government department and its policy-advisory community services board with the Department through which it provides state and federal funds appropriated for mental health, mental retardation and substance abuse services to that operating community services board, administrative policy community services board or local government department with a policy-advisory community services board.

"Policy-advisory community services board" or "policy-advisory board" means the public body organized in accordance with the provisions of this chapter that is appointed by and accountable to the local governing body of each political subdivision that established it to provide advice on policy matters to the local government department that provides mental health, mental retardation and substance abuse services pursuant to §§ 37.1-197 A and 37.1-197.1. The "policy-advisory community services board" or "policy-advisory board" denotes the board, the members of which are appointed pursuant to § 37.1-195 with the powers and duties enumerated in § 37.1-197 C.

§ 37.1-195. Community services board; appointment; membership; duties of fiscal agent.

A. Every city, county or combination of counties or cities or counties and cities ~~establishing a community mental health, mental retardation and substance abuse services program~~, before it shall come within the provisions of this ~~act~~ *chapter*, shall establish a single community services board, with neither less than ~~five~~ *six* nor more than eighteen members. When any city or county singly establishes a ~~program~~ *community services board*, the board shall be appointed by the governing body of the local political subdivision establishing ~~such a program~~ *the board.* When any combination of counties or cities or counties and cities establishes a community services ~~program~~ *board*, the board of supervisors of each county ~~in the case of counties~~ or the council ~~in the case~~ of ~~cities~~ *each city* shall ~~establish~~ *mutually agree on* the size of the board~~, shall elect~~ and appoint the members of the *community services* board ~~and shall designate an official of one member city or county to act as fiscal agent for the board~~.

Appointments to the community services board shall be broadly representative of the community ~~and shall include representation by~~. *One-third of the appointments to the board shall be identified* consumers or family members of consumers, *at least one of whom shall be a consumer receiving services. One or more members may be nongovernmental service providers.* Sheriffs or their designees shall also be included, when practical.

~~The county or city which comprises a single board and the county or city whose designated official serves as fiscal agent for the board in the case of joint boards shall annually audit the total revenues of the board and its programs and shall, in conjunction with the other participating political subdivisions in the case of joint boards, arrange for the provision of legal services to the board.~~

No such board shall be composed of a majority of ~~elected~~ *local government* officials, *elected or appointed,* as members, nor shall any county or city be represented on such board by more than ~~one~~ *two* elected ~~official~~ *or appointed officials.*

The board appointed pursuant to this section shall be responsible to the governing body or bodies of the county or city or combination thereof ~~which~~ *that* established such board.

B. A city council or county board of supervisors may designate its community services board as (i) an operating board, (ii) an administrative policy board, or (iii) a policy-advisory board. A combination of cities or counties or cities and counties may establish a joint community services board either as (i) an operating board, (ii) an administrative policy board, or (iii) a policy-advisory board.

C. The county or city or combination of cities or counties, or cities and counties that establishes an operating board shall receive an independent annual audit of the total revenues, expenditures, and data of that operating board, and shall provide a copy of the audit to the Department. The county or city or combination of cities or counties or cities and counties that establishes an operating board shall designate an official of one member city or county to act as fiscal agent for the board. The county or city whose designated official serves as fiscal agent for the board in the case of joint

boards shall review and act upon the independent audit of the board, and shall, in conjunction with the other participating political subdivisions, arrange for the provision of legal services to the board.

D. The county or city or combination of cities or counties, or cities and counties that establishes an administrative policy board shall receive an independent annual audit of the total revenues, expenditures, and data of the administrative policy board, provide a copy of the audit to the Department, and arrange for the provision of legal services to the board. When a combination of cities or counties establishes an administrative policy board, the participating subdivisions shall designate an official of one member city or county to act as fiscal agent for the board. The county or city whose designated official serves as fiscal agent for the board in the case of joint boards shall review and act upon the independent audit of the board, and shall, in conjunction with the other participating political subdivisions in the case of joint boards, arrange for the provision of legal services to the board.

E. The county or city or combination of cities or counties, or cities and counties that establishes a policy-advisory board shall provide an annual audit of the total revenues, expenditures, and data of the city or county government department to the board and the Department, carry out the responsibilities and duties enumerated in §§ 37.1-197 A and 37.1-197.1, and provide legal services to the board. When a combination of cities or counties or cities and counties establishes a policy-advisory board, the participating subdivisions shall designate which local government shall operate the city or county government department. This local government shall provide an annual audit of the total revenues, expenditures, and data of that department to the board and the Department, carry out the responsibilities and duties enumerated in §§ 37.1-197 A and 37.1-197.1, and, in conjunction with the other participating political subdivisions in the case of joint boards, arrange for the provision of legal services to the board.

§ 37.1-196. Same; term; vacancies; removal.

The term of office of each member of the *operating* community services boards, *the administrative policy boards, or policy-advisory boards* shall be for three years from ~~the first day of~~ January *1* of the year of appointment, or, at the option of the governing body of a county or city, from ~~the first day of~~ July *1* of the year of appointment, except that of the members first appointed, several shall be appointed for terms of one year each, several for terms of two years each, and the remaining members of the board for terms of three years each. The selection of members for one-*year*, two-*year*, and three-year terms shall be as nearly equal as possible with regard to the total number of members on the board. If a governing body has appointed members for terms commencing January ~~one~~ *1* or July ~~one~~ *1* but desires to change the date the terms of office commence, the governing body may, as the terms of the members then in office expire, appoint successors for terms of two and one-half or three and one-half years so as to expire on June ~~thirty~~ *30* or December ~~thirty-one~~ *31*. Vacancies shall be filled for unexpired terms in the same manner as original appointments. No person shall be eligible to serve more than ~~two successive~~ *three full three-year* terms; ~~provided that~~ *however*, persons heretofore or hereafter appointed to fill vacancies may serve ~~two~~ *three* additional ~~successive~~ *full three-year* terms. Any member of a board may be removed by the appointing authority for cause, after being given a written statement of the causes and an opportunity to be heard thereon.

§ 37.1-196.1. Compensation of board members.

The governing body of any county or city, or the governing bodies of any combination thereof, which establishes ~~a~~ *an operating* community services board, *an administrative policy board, or a policy-advisory board* may, out of the general fund or funds of the participating political subdivisions, pay to each member of the board not in excess of $600 per year as compensation for his attendance at meetings of the board. No political subdivision shall be reimbursed out of either state or federal funds for any part of the compensation paid.

§ 37.1-197. Community services boards; local government department; powers and duties.

A. Every *operating* community services board *or local government department with a policy-advisory board* shall *have the following powers and duties*:

1. Review and evaluate all existing and proposed public community mental health, mental retardation and substance abuse services and facilities available to serve the community and such private services and facilities as receive funds through ~~the board~~ *it* and advise the ~~appropriate~~ local ~~governments~~ *governing body or bodies of the political subdivision or subdivisions that established it*

as to its findings.

2. *Pursuant to § 37.1-198,* submit to the governing body ~~or bodies~~ of each political subdivision~~, of which~~ *that established* it ~~is an agency, a program of~~ *an annual performance contract for* community mental health, mental retardation and substance abuse services ~~and facilities~~ for its approval *prior to submission of the contract to the Department.*

3. Within amounts appropriated therefor, ~~execute such programs and maintain~~ *provide* such services as may be authorized under such ~~appropriations~~ *performance contract.*

4. In accordance with its approved ~~program~~ *performance contract,* enter into contracts *with other providers* for *the* rendition or operation of services or facilities.

5. *In the case of operating boards,* make rules, *policies,* or regulations concerning the rendition or operation of services and facilities under its direction or supervision, subject to applicable standards, *policies,* or regulations promulgated by the State Board.

6. *In the case of operating boards,* appoint ~~a coordinator or~~ *an executive* director of community mental health, mental retardation and substance abuse services, according to minimum qualifications ~~as may be~~ established by the Department, and prescribe his duties. The compensation of ~~such coordinator or~~ *the executive* director shall be fixed by the *operating* board within the amounts made available by appropriation therefor. *The executive director shall serve at the pleasure of the operating board and be employed under an annually renewable contract that contains performance objectives and evaluation criteria. For operating boards, the Department shall approve (i) the selection of the executive director for adherence to minimum qualifications established by the Department and (ii) the salary ranges of the executive director and senior management staff. In the case of a local government department with a policy-advisory board, the director of the local government department shall serve as the executive director. The policy-advisory board shall participate in the selection and the annual performance evaluation of the executive director, according to minimum qualifications established by the Department. The compensation of the executive director shall be fixed by local government in consultation with the policy-advisory board within the amounts made available by appropriation therefor.*

7. Prescribe a reasonable schedule of fees for services provided by personnel or facilities under the jurisdiction or supervision of the board and *establish procedures for the* collection of the same. All fees collected shall be included in the ~~program~~ *performance contract* submitted to the local governing body or bodies pursuant to subdivision 2 hereof and ~~in the budget submitted to the local governing body or bodies pursuant to~~ § 37.1-198 and shall be used only for community mental health, mental retardation and substance abuse purposes. Every *operating* board *and local government department with a policy-advisory board* shall institute a reimbursement system to maximize the collection of fees from persons receiving services under ~~the~~ *their* jurisdiction or supervision ~~of the board~~ consistent with the provisions of § 37.1-202.1 and from responsible third-party payors. *Operating* boards *and local government departments with policy-advisory boards* shall not attempt to bill or collect fees for time spent participating in involuntary commitment hearings pursuant to § 37.1-67.3.

8. Accept or refuse gifts, donations, bequests or grants of money or property from any source and utilize the same as authorized by the governing body or bodies of the political subdivision or subdivisions ~~of which~~ *that established* it ~~is an agency~~.

9. Seek and accept funds through federal grants. In accepting such grants the *operating* board *or local government department with a policy-advisory board* shall not bind the governing body or bodies of the political subdivision or subdivisions ~~of which~~ *that established* it ~~is an agency~~ to any expenditures or conditions of acceptance without the prior approval of such governing body or bodies.

10. Have authority, notwithstanding any provision of law to the contrary, to disburse funds appropriated to it in accordance with such regulations as may be established by the governing body *or bodies* of the political subdivision ~~of which the board is an agency or, in the case of a joint board, as may be established by agreement~~ *or subdivisions that established it.*

11. Apply for and accept loans as authorized by the governing body or bodies of the political subdivision or subdivisions ~~of which~~ *that established* it ~~is an agency~~. This provision is not intended to affect the validity of loans so authorized and accepted prior to July 1, 1984.

12. Develop joint annual written agreements, consistent with policies and procedures established by the State Board, with local school divisions; health departments; boards of social services; housing

agencies, where they exist; courts; sheriffs; area agencies on aging and regional Department of Rehabilitative Services offices. The agreements shall specify what services will be provided to ~~clients~~ *consumers.* All participating agencies shall develop and implement the agreements and shall review the agreements annually.

13. Develop and submit to the Department the necessary information for the preparation of the Comprehensive State Plan for mental health, mental retardation and substance abuse services pursuant to § 37.1-48.1.

14. Take all necessary and appropriate actions to maximize the involvement and participation of consumers and family members of consumers in policy formulation and services planning, delivery, and evaluation.

15. Institute, singly or in combination with other operating boards, administrative policy boards, local government departments with policy-advisory boards, or behavioral health authorities a dispute resolution mechanism that is approved by the Department and enables consumers and family members of consumers to resolve concerns, issues, or disagreements about services without adversely affecting their access to or receipt of appropriate types and amounts of current or future services from the operating board or local government department with a policy-advisory board.

16. Notwithstanding the provisions of § 37.1-84.1 or any regulations promulgated thereunder, release data and information about individual consumers to the Department so long as the Department implements procedures to protect the confidentiality of such information.

B. Every administrative policy community services board shall:

1. Review and evaluate all existing and proposed public community mental health, mental retardation and substance abuse services and facilities available to serve the community and such private services and facilities as receive funds through it and advise the local governing body or bodies of the political subdivision or subdivisions that established it as to its findings.

2. Pursuant to § 37.1-198, submit to the governing body of each political subdivision that established it, an annual performance contract for community mental health, mental retardation and substance abuse services for its approval prior to submission of the contract to the Department.

3. Within amounts appropriated therefor, provide such services as may be authorized under such performance contract.

4. In accordance with its approved performance contract, enter into contracts with other providers for the rendition or operation of services or facilities.

5. Make rules, policies, or regulations concerning the rendition or operation of services and facilities under its direction or supervision, subject to applicable standards, policies or regulations promulgated by the State Board.

6. Participate with local government in the appointment and annual performance evaluation of an executive director of community mental health, mental retardation and substance abuse services, according to minimum qualifications established by the Department, and prescribe his duties. The compensation of the executive director shall be fixed by local government in consultation with the board within the amounts made available by appropriation therefor.

7. Prescribe a reasonable schedule of fees for services provided by personnel or facilities under the jurisdiction or supervision of the board and establish procedures for the collection of the same. All fees collected shall be included in the performance contract submitted to the local governing body or bodies pursuant to subdivision 2 of this subsection and § 37.1-198 and shall be used only for community mental health, mental retardation and substance abuse purposes. Every administrative policy board shall institute a reimbursement system to maximize the collection of fees from persons receiving services under their jurisdiction or supervision consistent with the provisions of § 37.1-202.1 and from responsible third-party payors. Administrative policy boards shall not attempt to bill or collect fees for time spent participating in involuntary commitment hearings pursuant to § 37.1-67.3.

8. Accept or refuse gifts, donations, bequests or grants of money or property from any source and utilize the same as authorized by the governing body or bodies of the political subdivision or subdivisions that established it.

9. Seek and accept funds through federal grants. In accepting such grants, the administrative policy community services boards shall not bind the governing body or bodies of the political subdivision or subdivisions that established it to any expenditures or conditions of acceptance without

the prior approval of such governing body or bodies.

10. Have authority, notwithstanding any provision of law to the contrary, to disburse funds appropriated to it in accordance with such regulations as may be established by the governing body or bodies of the political subdivision or subdivisions that established it.

11. Apply for and accept loans as authorized by the governing body or bodies of the political subdivision or subdivisions that established it.

12. Develop joint annual written agreements, consistent with policies and procedures established by the State Board, with local school divisions; health departments; boards of social services; housing agencies, where they exist; courts; sheriffs; area agencies on aging; and regional Department of Rehabilitative Services offices. The agreements shall specify what services will be provided to consumers. All participating agencies shall develop and implement the agreements and shall review the agreements annually.

13. Develop and submit to the local governing body of each political subdivision that established it and to the Department the necessary information for the preparation of the Comprehensive State Plan for mental health, mental retardation and substance abuse services pursuant to § 37.1-48.1.

14. Take all necessary and appropriate actions to maximize the involvement and participation of consumers and family members of consumers in policy formulation and services planning, delivery, and evaluation.

15. Institute, singly or in combination with other operating community services boards, administrative policy boards, local government departments with policy-advisory boards, or behavioral health authorities, a dispute resolution mechanism that is approved by the Department and enables consumers and family members of consumers to resolve concerns, issues, or disagreements about services without adversely affecting their access to or receipt of appropriate types and amounts of current or future services from the administrative policy board.

16. Notwithstanding the provisions of § 37.1-84.1 or any regulations promulgated thereunder, release data and information about individual consumers to the Department so long as the Department implements procedures to protect the confidentiality of such information.

17. Carry out other duties and responsibilities as assigned by the governing body of each political subdivision that established it.

By local agreement between the administrative policy board and the governing body of the political subdivision that established it, additional responsibilities may be carried out by the local government, including, but not limited to, personnel or financial management. In the case of administrative policy boards established by more than one city or county, the participating subdivisions shall designate which local government shall assume these responsibilities.

C. Every policy-advisory community services board, with staff support provided by the director of the local government department, shall:

1. Advise the local government regarding rules, policies, or regulations for the rendition or operation of services and facilities by the local government department, subject to applicable standards, policies, or regulations promulgated by the State Board.

2. Review and evaluate the operations of the local government department and advise the local governing body of each political subdivision that established it as to its findings.

3. Review the community mental health, mental retardation and substance abuse services developed by the local government department and advise the local governing body of each political subdivision that established it as to its findings.

4. Review and comment on the annual performance contract, quarterly and annual performance reports, and Comprehensive State Plan proposals developed by the local government department. The board's comments shall be attached to the performance contract, performance reports, and Comprehensive State Plan proposals prior to their submission to the local governing body of each political subdivision that established it and to the Department.

5. Advise the local government as to the necessary and appropriate actions to maximize the involvement and participation of consumers and family members of consumers in policy formulation and services evaluation.

6. Participate in the selection and the annual performance evaluation of the local government department director employed by the city or county.

7. Carry out other duties and responsibilities as assigned by the governing body of each political subdivision that established it.

§ 37.1-197.1. Prescription team; prescreening; predischarge planning.

A. In order to provide comprehensive mental health, mental retardation and substance abuse services within a continuum of care, the *operating* community services board, *administrative policy board or local government department with a policy-advisory board* shall *function as the single point of entry into the publicly funded mental health, mental retardation and substance abuse services system and shall fulfill the following responsibilities*:

1. Establish and coordinate the operation of a prescription team ~~which~~ *that* shall be composed of representatives from the *operating* community services board, *administrative policy board or local government department with a policy-advisory board*, social services or public welfare department, health department, Department of Rehabilitative Services *office* serving in the community services board's area and, as appropriate, the social services staff of the state institution*(s)* serving the community services board's catchment area and the local school division. Such other human resources agency personnel may serve on the team as the team deems necessary. The team, under the direction of the *operating* community services board, *administrative policy board or the local government department with a policy-advisory board*, shall be responsible for integrating the community services necessary to accomplish effective prescreening and predischarge planning for ~~clients~~ *consumers* referred to the *operating* community services board, *administrative policy community services board, or local government department with a policy-advisory board.* When prescreening reports are required by the court on an emergency basis pursuant to § 37.1-67.3, the team may designate one team member to develop the report for the court and report thereafter to the team.

2. Provide prescreening services prior to the admission for treatment pursuant to § 37.1-65 or § 37.1-67.3 of any person who requires emergency mental health services while in a political subdivision served by the *operating community services* board, *administrative policy board or local government department with a policy-advisory board.*

3. ~~Cooperate and participate~~ *Provide,* in *consultation with the appropriate state mental health facility or training center,* predischarge planning for any person, who prior to ~~hospitalization~~ *admission,* resided in a political subdivision served by the *operating community services* board, *administrative policy board, or local government department with a policy-advisory board* or who chooses to reside after hospitalization in a political subdivision served by the board, who is to be released from a state ~~hospital~~ *mental health facility or training center* pursuant to § 37.1-98. *The predischarge plan shall be completed prior to the person's discharge. The plan shall be prepared with the involvement and participation of the consumer or his representative and must reflect the consumer's preferences to the greatest extent possible. The plan shall include the mental health, mental retardation, substance abuse, social, educational, medical, employment, housing, legal, advocacy, transportation, and other services that the consumer will need upon discharge into the community and identify the public or private agencies that have agreed to provide them.*

4. No person shall be discharged from a state mental health facility or training center without completion by the operating board, administrative policy board, or local government department with a policy-advisory board of the predischarge plan described in subdivision 3 of this subsection. If state facility staff identify a patient or resident as ready for discharge and the operating board, administrative policy board, or local government department with a policy-advisory board that is responsible for the person's care disagrees, the operating board, administrative policy board or local government department with a policy-advisory board shall document in the treatment plan within thirty days of such person's identification any reasons for not accepting the person for discharge. If the state facility disagrees with the operating board, administrative policy board, or local government department with a policy-advisory board and the operating board, administrative policy board, or local government department with a policy-advisory board refuses to develop a predischarge plan to accept the person back into the community, the state facility or the operating board, administrative policy board, or local government department with a policy-advisory board shall request the Commissioner to review the state facility's determination that the person is ready for discharge in accordance with procedures established in the performance contract. If the Commissioner determines that the person is ready for discharge, a predischarge plan shall be developed by the Department to

ensure the availability of adequate services for the consumer and the protection of the community. The Commissioner shall also verify that sufficient state-controlled funds have been allocated to the operating board, administrative policy board, or local government department with a policy-advisory board through the performance contract. If sufficient state-controlled funds have been allocated, the Commissioner may contract with a private provider or another operating board, administrative policy board, or local government department with a policy-advisory board to deliver the services specified in the predischarge plan and withhold funds allocated applicable to that consumer's predischarge plan from the operating board, administrative policy board, or local government department with a policy-advisory board in accordance with § 37.1-198 C and E.

B. The *operating* community services board, *administrative policy board, or local government department with a policy-advisory board* may perform the functions set out in ~~subsection A hereof~~ *subdivision A 1, regarding the prescription team,* in the case of children by referring ~~clients~~ *consumers* who are minors to the locality's family assessment and planning team and *by* cooperating with the community policy and management team in the coordination of services for troubled youths and their families. *The operating board, administrative policy board, or local government department with a policy-advisory board may involve the family assessment and planning team and the community policy and management team, but it remains responsible for performing the functions set out in subdivisions A 2 and A 3 in the case of children.*

§ 37.1-197.2. Background checks required.

A. Every *operating* community services board, *administrative policy board, local government department with a policy-advisory board* and behavioral health authority shall, on and after July 1, 1997, require any applicant who accepts employment in any direct ~~client~~ *consumer* care position with the *operating* community services board, *administrative policy board, local government department with a policy-advisory board* or behavioral health authority to submit to fingerprinting and provide personal descriptive information to be forwarded through the Central Criminal Records Exchange to the Federal Bureau of Investigation (FBI) for the purpose of obtaining national criminal history record information regarding such applicant.

The Central Criminal Records Exchange, upon receipt of an individual's record or notification that no record exists, shall submit a report to the requesting executive director of the *operating* community services board, *administrative policy board, local government department with a policy-advisory board* or the behavioral health authority. If any applicant is denied employment because of information appearing on the criminal history record and the applicant disputes the information upon which the denial was based, the Central Criminal Records Exchange shall, upon request, furnish the applicant the procedures for obtaining a copy of the criminal history record from the Federal Bureau of Investigation. The information provided to the executive director of any *operating* community services board, *administrative policy board, local government department with a policy-advisory board* or behavioral health authority shall not be disseminated except as provided in this section.

B. ~~The~~ *Operating* community services boards, *administrative policy boards, local government departments with policy-advisory boards* and behavioral health authorities shall also require, as a condition of employment for all such applicants, written consent and personal information necessary to obtain a search of the registry of founded complaints of child abuse and neglect maintained by the Department of Social Services pursuant to § 63.1-248.8.

C. The cost of obtaining the criminal history record and search of the child abuse and neglect registry record shall be borne by the applicant, unless the *operating* community services board, *administrative policy board, local government department with a policy-advisory board* or behavioral health authority, at its option, decides to pay such cost.

D. As used in this section, the term "direct ~~client~~ *consumer* care position" means any position with a job description that includes responsibility for (i) treatment, case management, health, safety, development or well-being of a ~~client~~ *consumer*, or (ii) immediately supervising a person in a position with such responsibility.

§ 37.1-198. Performance contract for mental health, mental retardation and substance abuse services.

A. The Department shall develop and initiate negotiation of the performance contracts through which it provides funds to operating boards, administrative policy boards or local government

departments with policy-advisory boards to accomplish the purposes set forth in this chapter. Six months prior to the beginning of each fiscal year, the Department shall make available to the public the standard performance contract form that it intends to use as the performance contract for that fiscal year, and solicit public comments for a period of sixty days.

B. Any ~~city, county or combination of counties or cities or counties and cities which establishes a~~ *operating* community services board ~~administering a mental health, mental retardation and substance abuse services program~~, *administrative policy board, or local government department with a policy-advisory board* may apply for the assistance ~~as~~ provided in this ~~act~~ *chapter* by submitting annually to the Department its ~~plan and budget~~ *proposed performance contract* for the next fiscal year together with the *(i)* recommendations of the *operating* community services board ~~thereon~~ *or administrative policy board's board of directors or the local government department's policy-advisory board and (ii) the approval by formal vote of the governing body of each political subdivision that established it.* ~~The plan and budget shall include a comprehensive needs assessment of the service area, an inventory of available services provided by the board and other local agencies and expected utilization of such services.~~ *The operating board, administrative policy board or local government department with a policy-advisory board shall make its proposed performance contract available for public review and solicit public comments for a period of thirty days prior to submitting it for the recommendations of the operating board or administrative policy board's board of directors or the local government department's policy-advisory board. To avoid disruptions in service continuity, the Department may provide up to five semi-monthly payments of state-controlled funds to allow sufficient time to complete public review, public comment, negotiation and approval of the performance contract. If the governing body of each political subdivision does not approve the proposed performance contract by September 15 of each year, the performance contract shall be deemed approved.*

C. The performance contract shall (i) delineate the responsibilities of the Department and the operating board, administrative policy board or the local government department and its policy-advisory board; (ii) specify conditions that must be met for the receipt of state-controlled funds; (iii) identify the groups of consumers to be served with state-controlled funds; (iv) beginning on July 1, 2000, contain specific consumer outcome, provider performance, consumer satisfaction, and consumer and family member participation and involvement measures, and state facility bed utilization targets that have been negotiated with the operating board, administrative policy board or local government department with a policy-advisory board; (v) establish an enforcement mechanism, including notice and an appeal process, should an operating board, administrative policy board or local government department with a policy-advisory board fail to comply with any provisions of the contract, including provisions for remediation, the withholding of funds, methods of repayment of funds, and for the Department to exercise the provision of subsection E; and (vi) include reporting requirements and revenue, cost, service, and consumer information displayed in a consistent, comparable format determined by the Department.

The Department may provide for performance monitoring by an administrative services organization under contract with the Department in order to determine whether the operating boards, administrative policy boards or local government departments with policy-advisory boards are performing in accordance with the requirements of their respective performance contract.

D. No ~~program~~ *operating community services board, administrative policy community services board or local government department with a policy-advisory board* shall be eligible ~~for a grant hereunder~~ *to receive state-controlled funds for mental health, mental retardation or substance abuse services after September 15 of each year* unless *(i)* its ~~plan and budget have~~ *performance contract has* been approved by the governing body ~~or bodies~~ of each political subdivision ~~of which~~ *that established* it ~~is an agency~~ and by the Department*; (ii) it provides service, cost, revenue, and aggregate and individual consumer data and information, notwithstanding the provisions of § 37.1-84.1 or any regulations promulgated thereunder, to the Department in the format prescribed by the Department; and (iii) beginning on July 1, 2000, it uses standardized cost accounting and financial management systems approved by the Department.*

E. If, after unsuccessful use of the remediation process described in the performance contract, an operating board or administrative policy board or local government department with a

policy-advisory board remains in substantial noncompliance with its performance contract with the Department, the Department may, after affording the operating board or administrative policy board or local government department with a policy-advisory board an adequate opportunity to use the appeal process described in the performance contract, terminate all or a portion of the contract. Using the state-controlled resources associated with that contract, the Department, after consulting with the governing body of each political subdivision that established the operating board, administrative policy board or local government department with a policy-advisory board, may negotiate a performance contract with another operating board, administrative policy board, or local government department with a policy-advisory board or a private nonprofit or for-profit organization or organizations to obtain services that were the subject of the terminated performance contract.

§ 37.1-199. Mental health, mental retardation and substance abuse services; allocation of funds by Department; withdrawal of funds.

~~(a)~~ *A.* At the beginning of each fiscal year the Department ~~may~~ *shall* allocate available *state-controlled* funds to ~~the~~ *operating* community services boards, *administrative policy boards, and local government departments with policy-advisory boards* for disbursement in accordance with ~~such~~ *Department* approved ~~plans and budgets~~ *performance contracts.*

B. From time to time during the fiscal year, the Department shall review the ~~budgets and expenditures~~ *performance reports* of the ~~various programs~~ *operating boards, administrative policy boards and local government departments with policy-advisory boards and the utilization management and review reports on their operations.* ~~If funds are not needed for a program to which they were allocated, the Department may withdraw such funds as are unencumbered, after reasonable notice and opportunity for hearing, and reallocate them to other programs. It~~ *The Department, after affording the operating board, administrative policy board or local government department with a policy-advisory board adequate opportunity to use the appeal process described in the performance contract,* may withdraw funds from any *operating* community services board ~~program which~~, *administrative policy board or local government department with a policy-advisory board that* is not being administered in accordance with ~~the~~ *its* approved ~~plan and budget of the community services board~~ *performance contract; that does not need the funds, based on its performance reports or utilization management and review reports;* or ~~which~~ *that* is not in compliance with the *operational* standards for ~~such a program as~~ *community services that are* promulgated by the State Board *or that do not meet provider performance, consumer outcome, consumer satisfaction or consumer and family member involvement measures in its performance contract.*

~~(b)~~ *C. The Department shall notify the governing body of each political subdivision that established the operating board, administrative policy board or local government department with a policy-advisory board before implementing any reduction of state-controlled funds. Before any political subdivision withdraws local government matching funds, it shall notify its operating board, administrative policy board or local government department with a policy-advisory board and the Department, since this could affect the amount of state-controlled funds provided by the Department.*

D. Allocations to be made to each ~~local~~ *operating* board, *administrative policy board, or local government department with a policy-advisory board* shall be determined by the Department after careful consideration of all of the following factors:

~~(1)~~. The total amount of funds appropriated for this purpose~~,~~*;*

~~(2)~~. The total amount of *matching* funds ~~requested~~ *appropriated* by the ~~local board,~~ *cities and counties participating in the community services board;*

~~(3)~~. The financial abilities of all of the cities and counties participating in the local *community services* board to provide funds required to generate the requested state match~~,~~*;*

~~(4)~~. The type and extent of ~~programs and~~ services ~~conducted~~ *provided* or planned by the ~~local~~ *operating community services* board, *administrative policy board or local government department with a policy-advisory board;*

~~(5)~~. The availability of services provided by the ~~local~~ *operating* board, *administrative policy board or local government department with a policy-advisory board* in the area served by it~~, and~~*;*

~~(6)~~. The ability of the ~~programs and~~ services provided by the ~~local~~ *operating* board, *administrative policy board, or local government department with a policy-advisory board* to decrease financial costs to the Department and increase the effectiveness of ~~patient~~ treatment *or training* by reducing the

number of ~~patients~~ *consumers* being admitted to or retained in state ~~hospitals~~ *mental health facilities and training centers* from the cities or counties participating in the ~~local~~ *community services* board; *and*

7. The performance of the operating board, administrative policy board or local government department with a policy-advisory board, as measured by provider performance, consumer outcome, consumer satisfaction, and consumer and family member involvement standards and criteria promulgated by the State Board.

~~(c)~~ *E.* Allocations to any one *operating* board, *administrative policy board, or local government department with a policy-advisory board* shall not exceed the following proportions, *unless a waiver is granted by the Department pursuant to policy promulgated by the State Board*:

~~(1)~~. For the construction of facilities: ninety percent of the total ~~costs of~~ *amount of state and local matching funds provided for* such construction.

~~(2)~~. For salaries and other operational costs: ninety percent of the total ~~costs~~ *amount of state and local matching funds provided for these expenses.*

~~(3) [Repealed.]~~

~~(d)~~ *F.* All fees collected ~~may~~ *shall* be kept by the *operating* board, *administrative policy board, or local government department with a policy-advisory board* and used for operational costs.

§ 37.1-202.1. Liability for expenses of services.

The income and estate of a ~~client~~ *consumer* shall be liable for the expenses of services ~~or facilities~~ under the jurisdiction or supervision of any *operating* community services board ~~which~~, *administrative policy board, or local government department with a policy-advisory board that* are utilized by the ~~client~~ *consumer.* Any person or persons responsible for holding, managing or controlling the income and estate of the ~~patient~~ *consumer* shall apply such income and estate toward the expenses of the services ~~or facilities~~ utilized by the ~~client~~ *consumer.*

Any person or persons responsible for the support of a ~~client~~ *consumer* pursuant to § 20-61 or a common law duty to support shall be liable for the expenses of services ~~or facilities~~ under the jurisdiction or supervision of any *operating* community services board ~~which~~, *administrative policy board, or local government department with a policy-advisory board that* are utilized by the ~~client~~ *consumer* unless the ~~client~~ *consumer*, regardless of age, qualifies for and is receiving aid under a federal or state program of assistance to the blind or disabled. Any such person or persons responsible for support of a ~~client~~ *consumer* pursuant to § 20-61 or a common-law duty to support shall no longer be financially liable, however, when a cumulative total of 1,826 days of (i) care and treatment or training for the ~~client~~ *consumer* in a state ~~hospital~~ *mental health facility or training center*; or (ii) the utilization by the ~~client~~ *consumer* of services ~~or facilities~~ under the jurisdiction or supervision of any *operating* community services board, *administrative policy board or local government department with a policy-advisory board*; or (iii) a combination of (i) and (ii) has passed, and payment for or a written agreement to pay the assessment for 1,826 days of care and services has been made. Not less than ~~3~~ *three* hours of service per day shall be required to include ~~1~~ *one* day in the cumulative total of 1,826 days of utilization of services under the jurisdiction or supervision of ~~a~~ *any operating* community services board, *administrative policy board, or local government department with a policy-advisory board.* In order to claim this exemption, the person or persons legally liable for the ~~client~~ *consumer* shall produce evidence sufficient to prove eligibility therefor.

§ 37.1-242. Behavioral health authorities; purpose.

Conditions resulting from evolving health care reform and behavioral health care delivery system reforms necessitate public instrumentalities to respond, organize, and effect ~~mental/~~behavioral health care coverage and services for citizens of the Commonwealth. *In* behavioral health authorities ~~are required so that~~, the administration of public funds resides at the same organizational level, the behavioral health authority, as the responsibility and accountability for consumers and services. Such a public instrumentality is in the public interest and hereby authorized consistent with the following legislative provisions.

§ 37.1-243. Definitions.

As used in this chapter, unless a different meaning clearly appears from the context:

"Authority" means a behavioral health authority, a public body and a body corporate and politic organized in accordance with the provisions of this chapter for the purposes and with the powers and

duties hereinafter set forth.

"Behavioral health" means the full range of mental health ~~care~~, mental retardation, ~~developmental disabilities~~ and substance abuse services~~,~~ and ~~the full range of~~ treatment modalities ~~including, but not limited to~~, *which shall include* emergency, ~~prevention, early intervention, outpatient,~~ *and case management services subject to such funds as may be appropriated therefor, and may include a comprehensive system of* inpatient, *outpatient,* day support, residential, *prevention, early intervention* and other appropriate *mental health, mental retardation and substance abuse* services ~~to effect an accessible and integrated continuum of care~~ *necessary to provide individualized services and supports to persons with mental illnesses, mental retardation, or alcohol or other drug abuse problems or dependence.*

"Behavioral health authority board of directors" means the public body organized in accordance with provisions of this chapter *that is appointed by* and accountable to the local governing ~~bodies~~ *body of the political subdivision that established it.*

"Behavioral health project" means all facilities suitable for providing adequate facilities and care for concentrated centers of population, and ~~shall also include~~ *includes* structures, buildings, improvements, additions, extensions, replacements, appurtenances, lands, rights in land, franchises, machinery, equipment, furnishings, landscaping, approaches, roadways and other facilities necessary or desirable in connection therewith or incidental thereto.

"Member" means ~~the respective~~ *a person appointed by the* local governing ~~body's appointee~~ *body* to the behavioral health authority board of directors.

"Performance contract" means the annual agreement negotiated by a behavioral health authority with the Department through which it provides state and federal funds appropriated for mental health, mental retardation and substance abuse services to that authority.

"Service area" means the ~~locality participating in and formulating~~ *political subdivision that established* the behavioral health authority.

"State Board" means the Virginia Mental Health, Mental Retardation and Substance Abuse Services Board.

"Unit" means any department, institution or commission of the Commonwealth and any public corporate instrumentality thereof, and any district, and ~~shall include~~ *includes* counties and municipalities.

§ 37.1-245. Board of directors; appointment; membership.

Every ~~locality~~ *city or county* establishing a behavioral health authority, before it comes within the provisions of this chapter, shall establish a board of directors with neither less than ~~five~~ *six* nor more than eighteen members. When any such ~~locality~~ *city or county* establishes a behavioral health authority, the board of directors shall be appointed by the governing body of the ~~locality~~ *political subdivision establishing the authority.* Appointments to the board of directors shall be broadly representative of the community~~, to include~~. *One-third of the appointments to the board shall be identified* consumers and family members of consumers, *at least one of whom shall be a consumer receiving services. One or more members may be nongovernmental services providers. Sheriffs or their designees shall also be included,* when practical.

No board of directors shall ~~be composed of a majority of~~ *include more than two local government* elected *or appointed* officials as members.

The board of directors appointed pursuant to this section shall be responsible to the governing body of the ~~locality which~~ *city or county that* established such authority.

The county or city that establishes a behavioral health authority shall receive an annual audit of the total revenues, expenditures and data from the authority and provide a copy of the audit to the Department.

§ 37.1-246. Board of directors; terms; vacancies; removal.

The term of office of each member of the behavioral health authority board of directors shall be for three years from January 1 of the year of appointment, or, at the option of the governing body of the ~~locality~~ *city or county*, from July 1 of the year of appointment, except that of the members first appointed, several shall be appointed for terms of one year each, several for terms of two years each, and the remaining members for terms of three years each. The selection of members for one-year, two-year, and three-year terms shall be as nearly equal as possible with regard to the total number of

members. If the governing body has appointed members for terms commencing January 1 or July 1 but desires to change the date the terms of office commence, the governing body may, as the terms of the members then in office expire, appoint successors for terms of two and one-half or three and one-half years so that the terms expire on June 30 or December 31. Vacancies shall be filled for unexpired terms in the same manner as original appointments. No person shall be eligible to serve more than ~~two successive~~ *three full three-year* terms, although persons appointed to fill vacancies may serve ~~two~~ *three* additional ~~successive~~ *full three-year* terms. Any member of the board of directors may be removed by the appointing governing body for cause, after being given a written statement of the causes and an opportunity to be heard thereon.

§ 37.1-247. Behavioral health authority board of directors officers; meetings.

The members of the behavioral health authority board of directors shall annually elect one of their members as chairman and another as vice-chairman and shall also elect a secretary and a treasurer for terms to be determined by the members, who may or may not be one of the members. The same person may serve as both secretary and treasurer. The members shall make such rules, regulations, and bylaws for their own government and procedure as they shall determine; they shall meet at least once each month and may hold such special meetings as they deem necessary. *Such rules, regulations, and bylaws shall be submitted to the governing body of the political subdivision that established the authority for review and comment.*

§ 37.1-248. Behavioral health authorities; powers and duties.

Every authority shall be deemed to be a public instrumentality, exercising public and essential governmental functions to provide for the public mental health, welfare, convenience and prosperity of the residents and such other persons who might be served by the authority and to provide behavioral health ~~care and related~~ services to such residents and persons. An authority ~~is authorized to exercise the~~ *shall have the* following powers *and duties*:

1. Review and evaluate all existing and proposed public community mental health, mental retardation, and substance abuse services and facilities available to serve the community and such private services and facilities as receive funds through the authority and advise the ~~locality~~ *governing body of the political subdivision that established it* as to its findings.

2. *Pursuant to § 37.1-248.1 and in order to obtain state, local, federal, Medicaid, and other revenues appropriated or reimbursed for the provision of mental health, mental retardation and substance abuse services, submit to the governing body of the political subdivision that established it an annual performance contract for community mental health, mental retardation, and substance abuse services for its approval prior to submission of the contract to the Department.*

~~2.~~ *3.* Within amounts ~~allocated by local, state, federal, Medicaid, and other payers, execute programs and services~~ *appropriated therefor, provide such services as may be authorized under such performance contract* for consumers in need.

~~3.~~ *4. In accordance with its approved performance contract, enter into contracts with other providers for the rendition or operation of services or facilities.*

4a. Make and enter into all *other* contracts or agreements, as the authority may determine, which are necessary or incidental to the performance of its duties and to the execution of powers granted by this chapter, including contracts with any federal agency, the Commonwealth, or with any unit thereof, behavioral health providers, insurers, and managed care/health care networks on such terms and conditions as the authority may approve.

~~4.~~ *5.* Make rules, *policies,* or regulations concerning the rendition or operation of services and facilities under its direction or supervision, subject to applicable standards, *policies,* or regulations promulgated by the State Mental Health, Mental Retardation and Substance Abuse Services Board.

~~5.~~ *6.* Appoint a chief executive officer of the behavioral health authority, *according to minimum qualifications established by the Department,* and prescribe his duties. The compensation of such chief executive officer shall be fixed by the authority ~~and he~~ *within the amounts made available by appropriation therefor. The chief executive officer* shall serve at the pleasure of the ~~authority~~ *authority's board of directors and be employed under an annually renewable contract that contains performance objectives and evaluation criteria. The Department shall approve (i) the selection of the chief executive officer for adherence to minimum qualifications established by the Department and (ii) the salary ranges of the chief executive officer and senior management staff.*

~~6.~~ *7.* Empower the chief executive officer to maintain a complement of professional staff to operate the behavioral health authority's service delivery system.

~~7.~~ *8.* Prescribe a reasonable schedule of fees for services provided by personnel or facilities under the jurisdiction or supervision of the authority and *establish procedures for the* collection of the same. *All fees collected shall be included in the performance contract submitted to the local governing body pursuant to subdivision 2 hereof and § 37.1-248.1 and shall be used only for community mental health, mental retardation and substance abuse purposes.* Every authority shall institute a reimbursement system to maximize the collection of fees from persons receiving services under the jurisdiction or supervision of the authority consistent with the provisions of § 37.1-202.1 and from responsible third-party payers. *Authorities shall not attempt to bill or collect fees for time spent participating in involuntary commitment hearings pursuant to § 37.1-67.3.*

~~8.~~ *9.* Accept ~~loans,~~ *or refuse gifts, donations, bequests, or* grants *of money or property,* or *other* assistance from the federal government, the Commonwealth, any municipality thereof, or from any other sources, public or private~~,~~*; utilize the same* to carry out any of its purposes*;* and enter into any agreement or contract regarding or relating to the acceptance or use or repayment of any such ~~loan,~~ grant or assistance.

10. Seek and accept funds through federal grants. In accepting such grants, the authority shall not bind the governing body of the political subdivision that established it to any expenditures or conditions of acceptance without the prior approval of such governing body.

~~9.~~ *11.* Notwithstanding any provision of law to the contrary, disburse funds ~~allocated to it in accordance with applicable regulations~~ *appropriated to it in accordance with applicable regulations.*

12. Apply for and accept loans in accordance with regulations established by the board of directors.

~~10.~~ *13.* Develop joint annual written agreements, consistent with policies and procedures established by the State Board, with local school divisions; health departments; boards of social services; housing agencies, where they exist; courts; sheriffs; area agencies on aging; and regional Department of Rehabilitative Services offices. The agreements shall specify what services will be provided to consumers. All participating agencies shall develop and implement the agreements and shall review the agreements annually.

14. Develop and submit to the Department the necessary information for the preparation of the Comprehensive State Plan for mental health, mental retardation and substance abuse services pursuant to § 37.1-48.1.

15. Take all necessary and appropriate actions to maximize the involvement and participation of consumers and family members of consumers in policy formulation and service planning, delivery, and evaluation.

16. Institute, singly or in combination with other operating boards, administrative policy boards, local governments with policy-advisory boards, or behavioral health authorities, a dispute resolution mechanism that is approved by the Department and enables consumers and family members of consumers to resolve concerns, issues, or disagreements about services without adversely affecting their access to or receipt of appropriate types and amounts of current or future services from the authority.

17. Notwithstanding the provisions of § 37.1-84.1 and regulations promulgated thereunder, release data and information about individual consumers to the Department, so long as the Department implements procedures to protect the confidentiality of such information.

~~11.~~ *18.* Fulfill all other duties *and be subject to applicable provisions* specified in the Code of Virginia pertaining to community services boards including, *but not limited to*: § 37.1-65.1 (judicial certification of eligibility for admission of mentally retarded persons); §§ 37.1-67.1 through 37.1-67.6 (involuntary detention); *§ 37.1-84.1 (human rights); § 37.1-98.2 (exchange of information; § 37.1-183.1 (licensure);* § 37.1-197.1 (prescription team); ~~§ 37.1-198 (plans and budgets);~~ *§ 37.1-197.2 (background checks);* § 37.1-199 (allocation of funds by the Department of Mental Health, Mental Retardation~~,~~ and Substance Abuse Services); and § 37.1-202.1 (consumer liability for expenses of services).

~~12. Fulfill all applicable rules, regulations and standards pertaining to the rendition of mental health, mental retardation, and substance abuse services including, but not limited to, confidentiality,~~

~~human research assurances, service and facility licensing, and client rights' protection.~~

~~13. As a public instrumentality, ensure compliance with all applicable organizational and administrative rules, regulations and standards pertaining to human resources; equal employment; fair labor practices; public procurement; risk management; and governmental finance and accounting requirements.~~

~~14.~~ *19.* Make loans and provide other assistance to corporations, partnerships, associations, joint ventures or other entities in carrying out any activities authorized by this chapter.

~~15.~~ *20.* Transact its business, locate its offices and control, directly or through stock or nonstock corporations or other entities, facilities that will assist the authority in carrying out the purposes and intent of this chapter, including without limitations the power to own or operate, directly or indirectly, behavioral health facilities in its service area.

~~16. Plan, design, construct, renovate, enlarge, equip, maintain and operate programs for the purpose of providing behavioral health care and related services and other appropriate purposes.~~

~~17.~~ *21.* Acquire property, real or personal, by purchase, gift, *or* devise on such terms and conditions, and in such manner as it may deem proper, and such rights, easements or estates therein as may be necessary for its purposes, and sell, lease and dispose of the same, or any portion thereof or interest therein, whenever it shall become expedient to do so.

~~18.~~ *22.* Participate in joint ventures with individuals, corporations, partnerships, associations or other entities for providing behavioral health care or related services or other activities that the authority may undertake to the extent that such undertakings assist the authority in carrying out the purposes and intent of this chapter.

~~19.~~ *23.* Conduct or engage in any lawful business, activity, effort or project, necessary or convenient for the purposes of the authority or for the exercise of any of its powers.

~~20.~~ *24.* As a public instrumentality, operationalize its administrative management infrastructure in whole or in part independent of the local governing body; however, nothing in the chapter precludes behavioral health authorities from acquiring support services through existing government entities.

~~21.~~ *25.* Operationalize capital improvements and bonding through existing economic or industrial development authorities.

~~22.~~ *26.* Establish retirement, group life insurance, and group accident and sickness insurance plans or systems for its employees in the same manner as cities, counties and towns are permitted under § 51.1-801.

~~23.~~ *27.* Make an annual report to the ~~State~~ *Virginia Department of* Mental Health, Mental Retardation and Substance Abuse Services ~~Board~~ of the authority's activities.

~~24.~~ *28.* Ensure a continuation of all ~~client~~ *consumer* services during any transition period.

§ 37.1-248.1. Performance contract for mental health, mental retardation and substance abuse services.

A. The Department shall develop and initiate negotiation of the performance contracts through which it provides funds to behavioral health authorities to accomplish the purposes set forth in this chapter. Six months prior to the beginning of each fiscal year, the Department shall make available to the public the standard performance contract form that it intends to use as the performance contract for that fiscal year, and solicit public comments for a period of sixty days.

B. Any behavioral health authority may apply for the assistance provided in this chapter by submitting annually to the Department its proposed performance contract for the next fiscal year together with the recommendations of the behavioral health authority's board of directors and the approval by formal vote of the governing body of the political subdivision that established it. The behavioral health authority shall make its proposed performance contract available for public review and solicit public comments for a period of thirty days prior to submitting it for the recommendations of the behavioral health authority's board of directors. To avoid disruptions in service continuity, the Department may provide up to five semi-monthly payments of state-controlled funds to allow sufficient time to complete public review, public comment, negotiation and approval of the performance contract. If the governing body of each political subdivision does not approve the proposed performance contract by September 15 of each year, the performance contract shall be deemed approved.

C. The performance contract shall (i) delineate the responsibilities of the Department and the

behavioral health authority; (ii) specify conditions that must be met for the receipt of state-controlled funds; (iii) identify the groups of consumers to be served with state-controlled funds; (iv) beginning on July 1, 2000, contain specific consumer, provider performance, consumer satisfaction and consumer and family member participation and involvement measures, and state facility bed utilization targets that have been negotiated with the behavioral health authority; (v) establish an enforcement mechanism, including notice and an appeal process, should the behavioral health authority fail to comply with any provisions of the contract, including provisions for remediation, the withholding of funds, methods of repayment of funds, and for the Department to exercise the provisions of subsection E hereof; and (vi) include reporting requirements and revenue, cost, service, and consumer information displayed in a consistent, comparable format determined by the Department.

D. No behavioral health authority shall be eligible to receive state-controlled funds for mental health, mental retardation or substance abuse services after September 15 of each year unless (i) its performance contract has been approved by the governing body of the political subdivision that established it and by the Department; (ii) it provides service, cost, revenue, and aggregate and individual consumer data and information, notwithstanding § 37.1-84.1 or any regulations promulgated thereunder, to the Department in the format prescribed by the Department; and (iii) beginning on July 1, 2000, it uses standardized cost accounting and financial management systems approved by the Department.

E. If, after unsuccessful use of the remediation process described in the performance contract, a behavioral health authority remains in substantial noncompliance with its performance contract with the Department, the Department may, after affording the authority an adequate opportunity to use the appeal process described in the performance contract, terminate all or a portion of the contract. Using the state-controlled resources associated with that contract, the Department, after consulting with the governing body of the political subdivision that established the behavioral health authority, may negotiate a performance contract with an operating board, an administrative policy board or a local government department with a policy-advisory board or a private nonprofit or for-profit organization or organizations to obtain services that were the subject of the terminated performance contract.

§ 37.1-250. Transfer of facilities and assets.

The governing body of the ~~locality~~ *political subdivision that established the authority* is authorized to transfer to the authority the operation and maintenance of such suitable facilities as are now or may be hereafter owned by the ~~locality,~~ *city or county* on such terms and conditions ~~which~~ *that* it may prescribe; but this section shall not be construed as authorizing the authority to maintain and operate such facilities until the operation thereof has been transferred by the governing body of the ~~locality~~ *political subdivision that established it.*

§ 37.1-251. Local appropriations.

The ~~locality~~ *city or county that established the authority* is authorized to make appropriations and to provide funds for the operation of the authority and to further its purposes. *Such appropriations for the authority shall be subject to the same requirements for operating boards, administrative policy boards and local government departments with policy-advisory boards as set forth in § 37.1-199.*

§ 37.1-252. Proceedings for dissolution.

Whenever it appears to the board of directors of a behavioral health authority that the need for such authority in the ~~locality~~ *city or county* in which it was created no longer exists, then, upon petition by the board of directors of the authority to the circuit court of such ~~locality~~ *city or county* after giving to the ~~locality~~ *city or county* ~~thirty~~ *ninety* days' notice~~,~~ and upon the production of the satisfactory evidence in support of such petition, the court may, in its discretion, enter an order declaring that the need for such authority in the ~~locality~~ *city or county* no longer exists and approving a plan for the winding up of the business of the authority, the payment or assumption of its obligations, and the transfer of its assets. *In order to be approved by the court, the court must find that this plan describes specifically how the city or county that established the authority will fulfill the same duties and responsibilities required for community services boards under §§ 37.1-194 through 37.1-202.1, and how the city or county will ensure continuity of care for consumers who are receiving services from the authority.*

§ 37.1-253. When powers and duties cease to exist.

If the court shall enter an order, as provided in § 37.1-252, that the need for such *behavioral health* authority no longer exists, then, except for the winding up of its affairs in accordance with the plan approved by the court, ~~its~~ *such authority's* authorities, powers and duties to transact business or to function shall cease to exist as of that date set forth in the order of the court.

APPENDIX VI-3

2/21/00

	House Document 77 (HD 77) Recommendation, Resolution, and Budget Bill Language	Source & Resources	Progress Notes
HD 77 # 1	The Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS), Community Services Boards (CSBs) and state facilities should increase the involvement and participation of consumers and family members in policy and decision-making; service development, operation, and evaluation; and in decisions about their treatment, habilitation, and recovery. The "best practice" strategies being developed through the Consumer and Family Involvement Pilot Projects of the Department should be used to form future policies, directives and actions of the State Board, DMHMRSAS, CSBs, other providers, and local governments.	Budget Bill Item 341 #2c FY 2000 -- $250,000 Report to: Governor and Chairmen of House Appropriations and Senate Finance Committees	• Report submitted December 1999. • Pilots completed. Lessons learned from the pilots will be incorporated into POMS. • Office of Consumer Affairs within the Office of Health and Quality Care established. • Language inserted in SFY 2000 and 2001 Performance Contracts regarding consumer and family member involvement. • Human Rights legislation (§ 37.1-84.3) enacted in 1999 provides for consumer and family members on LHRCs • DMHMRSAS, in collaboration with Va. Organizations of Consumers Asserting Leadership (VOCAL) sponsored a leadership training event 11/99 in Richmond provided by the Consumer Technical Assistance Center (CONTAC) of West Va.

	House Document 77 (HD 77) Recommendation, Resolution, and Budget Bill Language	Source & Resources	Progress Notes
HD 77 #2	The DMHMRSAS should work with the CSBs to expand the pool of service providers through incentives to private providers and by creating opportunities for consumers and family members to provide services.		• The Department established a Care Management Pilot and Private Provider Work Group consisting of representatives from the Virginia Hospital and Healthcare Association, the Virginia Network of Private Providers, the Virginia Municipal League, the Virginia Association of Counties, the Virginia Alliance for the Mentally Ill, the Arc of Virginia, PAIR, People First of Virginia, the Mental Health Association of Virginia, Parents of Children Coping Together, Adult Care Residences Association, the Department of Medical Assistance Services, the Virginia Association of Community Services Boards, state mental health and mental retardation facility staff, and a mental heath consumer. • Developed definition of care coordination. • Included language in the SFY 2000 and 2001 Performance Contracts, encouraging private sector provision of services to the extent possible and strengthened sections dealing with subcontracting. • Ongoing discussions regarding Performance Contract negotiations and implementation of managed care technology. • Expanded consumer-run programs through Mental Health and Substance Abuse Block Grant programs. • DMHMRSAS and Va. Mental Health Planning Council to issue RFP to expand consumer-run service programs.
HD 77 #3	The DMHMRSAS should ensure that performance measures included in the performance contracts for both state facilities and CSBs include consumer satisfaction indicators. These indicators should reflect the range and variety of services offered by providers and the consumer's perception of his or her ability to choose among appropriate and desirable local service providers.	HB 428	• Pilot projects completed. • POMS to begin data collection July 1, 2000. Full implementation targeted for July 1, 2001. • Report submitted to HJR 225 members November 1999.

	e Document 77 (HD 77) Recommendation, Resolution, and Budget Bill Language	Source & Resources	Progress Notes
HD 77 #4	The DMHMRSAS, CSBs and state facilities should develop and implement easy-to-use instruments to assess consumer and family member satisfaction and disseminate reports presenting the results of such surveys.	HB 428	• Consumer satisfaction instruments for child MH, adult MH and adult SA services have been developed and survey conducted in Fall 1999. Standardized instruments selected. Operations manual completed.
HD 77 #5	The DMHMRSAS and the CSBs should develop and implement consumer dispute resolution mechanisms that enable consumers and family members to raise and resolve with DMHMRSAS (including facilities) and CSBs concerns, issues, or disagreements about services without adversely affecting their access to or receipt of appropriate levels and amounts of current or future services from DMHMRSAS or CSBs.	HB 428	• Language was inserted in the SFY 2000 CSB Performance Contract requiring development of dispute resolution mechanisms that must be reviewed and approved by the Department. • Due to concerns about potential overlap and conflict with the human rights regulation procedures, this requirement was subsequently deferred to SFY 2001.
HD 77 #6	An education and advocacy network for the prevention and treatment of substance abuse should be created. This organization would educate the public and provide expertise for state and local policy development.	Not Funded	• Department staff are working with the statewide group, Substance Abuse Addiction Recovery Alliance (SAARA), to assist them in building membership and support. SAARA received a $100,000 grant from the Center for Substance Abuse Treatment to support the development of a statewide recovery network. • Development of the Consortium of SA Organizations in Virginia (CSAO). The CSAO is a grassroots organization whose purpose is to organize the various statewide substance abuse organizations into a unified group with a shared vision and goal for the statewide delivery system.
HD 77 #7	To ensure that issues of concern to local governments are resolved at the highest policy level, one member of the State Board shall be an elected local government official.	SB 495	• *Section 37.1-3* of *Code* amended, 1998. • Member appointed.

	House Document 77 (HD 77) Recommendation, Resolution, and Budget Bill Language	Source & Resources	Progress Notes
HD 77 #8	Legislation on priority populations should not be enacted this year. However, the State Board should use the results of the pilot projects on Priority Populations to begin the development of policies that define priority populations. The State Board should involve the Department, CSBs, Virginia Hospital and Healthcare Association, Virginia Network of Private Providers, and consumer and advocacy groups in the development of these policies.	SJR 153 (See HD 77 #17) Report to: Governor and General Assembly	• Report submitted to 2000 session. Senate Document No. 10, 2000. Statutory authority exists in *Section 37.1-198.* • Language on identifying and tracking priority populations included in draft SFY 2001 Performance Contract.
HD 77 #9	The State Board should provide oversight for the development and implementation of the Comprehensive State Plan.		• Comprehensive State Plan 2000-2006 distributed 1/12/2000.
HD 77 #10	The DMHMRSAS should establish statewide standards in areas of consumer access to services, outreach to consumers and families, service quality, consumer grievances and appeals, and consumer satisfaction. The Department should establish mechanisms for dealing with providers, including CSBs and state facilities, who do not comply with these standards.		• Statewide performance related to access, service quality, outcomes and satisfaction will be measured through POMS. • Benchmark data has been obtained for several indicators resulting from the Five-State Feasibility Study.
HD 77 #11	The DMHMRSAS should be authorized to contract with other public agencies and with private non-profit or for-profit organizations for local services when a CSB, after remediation efforts have proven to be unsuccessful, remains in substantial non-compliance with its performance contract or when the CSB fails to serve certain populations.	HB 428	• Completed. Language included in the Performance Contract.
HD 77 #12	The DMHMRSAS should establish a dispute resolution mechanism for private providers that contract with CSBs or state facilities to use if these providers cannot achieve a satisfactory resolution of issues, concerns, or problems with a CSB or state facility.		• The Care Management Pilot and Provider Work Group, which included representatives of the private sector, decided that this should be handled through standard contract provisions which are part of contracts negotiated with private providers, rather than developing a duplicative mechanism.

	'se Document 77 (HD 77) Recommendation, Resolution, and Budget Bill Language	Source & Resources	Progress Notes
HD 77 #13	The DMHMRSAS should develop more sophisticated management oversight systems (e.g., management information systems, utilization review staff and processes, quality assurance and consumer involvement mechanisms) and require adherence to these management practices through an enhanced Performance Contract with each CSB.	HJR 113	• DMHMRSAS will implement the phased introduction, beginning with a contract with an administrative services only organization, of new administrative and information services and financial management technologies to improve services system accountability and quality of care. • 1999 General Assembly appropriated funds to add two staff to the DMHMRSAS Office of Community Contracting to enhance contract monitoring. Positions are being recruited.
HD 77 #14	The DMHMRSAS, with input from CSBs, consumer and family groups, private providers, and local government representatives, should develop and implement an adult state psychiatric bed day allocation system through the CSB performance contract. This system should identify specific bed utilization targets for each CSB and include financial incentives or disincentives which should be applied through the CSB performance contracting mechanism.	HB 428	• Language inserted in the SFY 2000 Performance Contract to develop mechanism. • DMHMRSAS has established a workgroup to develop bed targets for adult acute and extended rehabilitation services, which will be incorporated in the FY 2001 Performance Contract. Incentives and disincentives will not be included the first year, but may be utilized in FY 2002. • Previous efforts that utilized national statistics are being reviewed for possible updating and use.
HD 77 #15	The DMHMRSAS should obtain the assistance of knowledgeable and experienced professional consultants, well versed in public mental health and mental retardation facility census management, as it develops this bed utilization target mechanism.		• See Item # 14

	House Document 77 (HD 77) Recommendation, Resolution, and Budget Bill Language	Source & Resources	Progress Notes
HD 77 #16	The DMHMRSAS should implement strategies and procedures that are intended to increase services access, effectiveness, and choice through competition and other practices that foster competition. Such practices include contract negotiation, publication and dissemination of report cards, outcome and performance measures, and consumer satisfaction surveys. These practices will help to mediate potential role conflicts. Actual or perceived conflicts of interests should be addressed by identifying and correcting deficiencies in consumer choice and satisfaction through contracting mechanisms. Provider performance measures and consumer satisfaction indicators should be used to evaluate the degree to which a CSB has addressed these dual function concerns.	HJR 113	• Ongoing
HD 77 #17	The DMHMRSAS should complete the pilot projects on Priority Populations and recommend by December 1, 1999 to the Governor and General Assembly legislation to implement priority populations. The draft legislation of the Joint Subcommittee should serve as the basis for the Department's review and recommendations.	SJR 153	• Report submitted to the 2000 session. Senate Document No. 10, 2000. • Pilots completed. • Legislation not required. Statutory authority exists in *Section 37.1-198.* • Language contained in draft SFY 2001 Performance Contract.

	e Document 77 (HD 77) Recommendation, Resolution, and Budget Bill Language	Source & Resources	Progress Notes
HD 77 #18	The DMHMRSAS should be required to develop and update a Comprehensive State Plan on a biennial basis. Before the next biennial update of the Comprehensive State Plan in 1999, the DMHMRSAS, with input from CSBs, state facilities, consumers and family members, advocacy groups, and local governments, should develop an easily applied, consistent, and quantifiable methodology to document the unmet needs for services. This methodology should clearly define what is included in the calculation of unmet needs and to which populations that methodology will be applied. The results of this methodology should be verifiable, at least on a sample basis.	HB 428	• Ongoing • Comprehensive State Plan 2000-2006 distributed 1/12/2000.
HD 77 #19	The DMHMRSAS should re-establish a separate Office of Substance Abuse Services to strengthen leadership and system planning.	HB 1292	• Completed
HD 77 #20	The DMHMRSAS should re-establish the Office of Prevention Services within the Department to provide leadership in planning, implementing, and evaluating prevention programs.	Not Funded	• Prevention has been established as a section of the Substance Abuse Services Office.

	House Document 77 (HD 77) Recommendation, Resolution, and Budget Bill Language	Source & Resources	Progress Notes
HD 77 #21	The DMHMRSAS should develop a Community and Facility Master Plan by December 1, 1998. The Community and Facility Master Plan should utilize nationally recognized private sector consultants to determine the future number of individuals that can be served in the communities, resources needed to provide appropriate community capacity, the numbers of individuals that will continue to require facility care, the optimum size, and location of facilities. The DMHMRSAS should ensure that representatives of consumers, families and advocacy groups participate in development of this Plan. Options for staff transition, economic impact on localities, and potential alternative uses for state facilities should be included in the final report. In addition, the master plan should determine the feasibility of utilizing other operating models for state facilities, such as operation of a facility or a specialized program area by a private contractor. As specific plans for downsizing or changing the use of facilities are formulated, the Department should work with the Virginia Municipal League and the Virginia Association of Counties to ensure that those local governments that will be most affected will be consulted and included in the formulation and implementation of any plans regarding state facilities.	Budget Bill Item 341 #6c See Item 96 Report to: Not Specified	• Completed December 1998.

	se Document 77 (HD 77) Recommendation, Resolution, and Budget Bill Language	Source & Resources	Progress Notes
HD 77 #22	The DMHMRSAS, with input from state facilities and CSBs, should examine and, where necessary, revise state facility catchment areas. This study should identify any proposed changes or realignments in facility catchment areas needed to improve CSB and state facility coordination, increase appropriate consumer access to state facility services nearer to home communities, and enhance pre-discharge planning and the best community placements for patients and residents in state facilities.		• State facility catchment areas have been refined as part of the targeted discharge and facility restructuring initiatives (i.e., individualized funded discharge projects, acute care initiative, etc.).
HD 77 #23	Given the current variability in admission and discharge criteria and protocols across state facilities, the DMHMRSAS, with input from facility directors and staff, CSBs, consumers and family members, and advocacy groups, should develop consistent and, where applicable, uniform clinical protocols for admission to and discharge from its facilities. The DMHMRSAS should seek consultation in the development of these protocols from managed care organizations or administrative services-only organizations that are experienced in the management of public mental health services.	HB 428	• The Department is in the final stages of completing the Facility Standardization Project. The first seven Departmental Instructions have been prepared and disseminated. The remaining DI's are nearing completion.
HD 77 #24	Whenever possible, acute short term psychiatric inpatient services should be provided in the community by private hospitals, which can receive Medicaid funding for this service. Local inpatient care for individuals who are not enrolled in Medicaid should be supported to the extent possible by state general funds allocated to the CSBs.		• In 1999 the General Assembly appropriated $2.5 million for a pilot project to purchase local in-patient psychiatric beds from the private sector. The Acute Care Pilot initiative in HPR IV addresses this issue. CSH will admit patients only after 28 days of local care.

	House Document 77 (HD 77) Recommendation, Resolution, and Budget Bill Language	Source & Resources	Progress Notes
HD 77 #25	The DMHMRSAS, in consultation with state facility directors, should develop and implement a consistent, uniform methodology for determining the actual numbers of beds funded at and operated by each state facility. These figures should become the official capacity figures for the state facility system for planning, costing, and census management purposes.		• Completed
HD 77 #26	The DMHMRSAS should develop and include options for state facility staff in any future planning regarding state mental health and mental retardation facilities. Among the options that should be considered are: • reasonable access to and priority for community services positions for which they are qualified by their training and experience, • access to a reasonable relocation package, • access to training, and • access to a reasonable severance packages, based on years of employment by the state.		• Ongoing activity of DMHMRSAS. Included in the Governor's Commission recommendation on restructuring ESH. • Language included in HB 1293 and SB 731, 2000.
HD 77 #27	CSBs that are actual departments of a city or county government should be distinguished from CSBs that function as autonomous operating boards.	HB 428	• Completed
HD 77 #28	Local governments should have flexibility to establish either a local government department with a policy-making board or an operating board. An operating board should function relatively independently of the local governments that created it.	HB 428	• Completed
HD 77 #29	CSBs should be local care coordinators and not the primary or only providers of services. Where this is not possible, the CSB, with the Department's authorization, may be the primary provider of services.		• Ongoing • See Item # 2

	se Document 77 (HD 77) Recommendation, Resolution, and Budget Bill Language	Source & Resources	Progress Notes
HD 77 #30	One-third of the appointments to CSBs shall be consumers or family members of consumers and at all times at least one member must be a consumer. Consumers and family members must be identified.	HB 428	• Completed • The Department collects information about CSB composition in a supplement to each CSB's annual Performance Contract.
HD 77 #31	Local governments should be permitted but not required to appoint to the CSB no more than two elected or appointed local government officials from any city or county belonging to the CSB, one of whom may be a sheriff, when practical. Private providers may also be appointed to the board.	HB 428	• No action required.
HD 77 #32	For CSBs that are not actual city or county government departments (operating CSBs), the DMHMRSAS should approve the selection of the executive director for adherence to minimum qualifications established by the Department.	HB 428	• Language was added in the Performance Contract to reflect language in HB 428, which requires CSB's to provide copies of job descriptions, annual contracts and advertisement for a new executive director. However, HB 428 did not authorize DMHMRSAS to approve the selection, only to establish minimum qualifications.
HD 77 #33	For operating CSBs, executive directors shall serve at the pleasure of the operating board and be employed under an annually renewable contract that contains clearly defined performance objectives and evaluation criteria.	HB 428	• Language was added in the Performance Contract to require CSB's to submit copies of employment contracts.
HD 77 #34	For operating CSBs, the salary ranges for executive directors and senior management staff (e.g., mental health, mental retardation, and substance abuse directors) should be reviewed and approved by the DMHMRSAS.	HB 428	• Language was added in the Performance Contract to reflect HB 428, which authorizes DMHMRSAS as to establish salary ranges but not to approve salary ranges.

	House Document 77 (HD 77) Recommendation, Resolution, and Budget Bill Language	Source & Resources	Progress Notes

HD 77 #35	(a) The CSBs' responsibilities for arranging discharge from state facilities should be clarified.
	
	(b) CSB staff who pre-screen individuals for temporary detention and commitment should be certified by the DMHMRSAS.
		HB 428
		
		HB 681 Budget Bill Item 347 #20c
		
		FY 1999 -- $75,000
		
		FY 2000 -- $75,000
			(a) Clarify CSB responsibilities for arranging discharge:
			• Clarified in legislation and departmental state facility clinical guidelines.
			• Language added to paragraph 6.g. of the CSB FY 1999 Performance Contract requires CSB's to develop regional protocols to implement provisions of *§37.1-197.1.* Admission and discharge practice expectations were addressed in the Continuity of Care effort. Department staff met with all CSB and state and facility directors twice to define continuity of care practice expectations. These expectations have been incorporated into the Performance Contracts with CSB's and state facilities.
			• SFY 2000 contract contains specific continuity of care requirements for CSB's.
			(b) Certification of CSB staff who pre-screen individuals:
			• The Department and the VACSB have collaborated to develop:
			  • Uniform pre-screening protocol now in use by all CSB's and state facilities.
			  • Minimum pre-screener qualifications adopted for implementation July 1, 1998 by all CSB's.
			  • A core curriculum for training of all pre-screeners was developed.
			  • Approximately 14,000 people trained by January 1, 1999.
			  • Additional training of new pre-screeners is ongoing.
			• Four videotapes were developed covering Risk Assessment, Capacity to Consent Treatment, Statutory Requirements for pre-screening, and the Uniform Pre-screening Protocol. Presented to pre-screeners statewide in facilitated meetings during 1998.

HD 77 #36	CSBs should contract with private providers for any service which can be provided effectively and at a reasonable cost.		• Ongoing

	se Document 77 (HD 77) Recommendation, Resolution, and Budget Bill Language	Source & Resources	Progress Notes
HD 77 #37	CSBs should be contractually responsible for the effective and efficient use of all state-controlled funds. This should occur through the management of funding allocations from the DMHMRSAS for individualized packages of services and supports and for general access services, such as emergency services, that will be available to any resident of the community, and through the management of state facility resources (bed days) allocated to CSBs through mechanisms such as bed utilization targets.	HB 428	• Language added to paragraph 6.a. of the FY 1999 and subsequent Performance Contract requires individual plans of care for specific appropriations. This includes the DAD state facility diversion project • SFY 2000 contract restructured to track costs and revenues for individualized services and plans. • Biennium allocations managed primarily through funding of individualized packages of services and supports.
HD 77 #38	Managed care practices such as pre-authorization, utilization review, consumer satisfaction surveys, and report cards should be integrated into CSB management practices and monitored by the DMHMRSAS through an enhanced performance contract.	HB 428	• DMHMRSAS to implement phased introduction of new administrative and information services and financial management technologies. (See Item # 13). • Department staff are developing a uniform CSB Cost Report.
HD 77 #39	The DMHMRSAS, with input from state facilities and CSBs, should examine the needs and opportunities for regional cooperation, existing models, and proposals for enhancing regional cooperation. The DMHMRSAS study should identify models that could be used when regional responses to an issue or situation are needed.		• Several regional initiatives have been initiated and continue where feasible (i.e., SA Diversion/Census Reduction Projects, Discharge and Diversion Project in Northern Virginia, Acute Care Pilot in Region IV).
HD 77 #40	The DMHMRSAS, with input from CSBs and representatives of private providers, such as the Virginia Hospital and Healthcare Association, Virginia Association of Health Maintenance Organizations, and Virginia Network of Private Providers, should develop specific proposals and strategies for increasing the provision of community services, especially local acute psychiatric inpatient services, across the state by private providers.		• The Department and the Virginia Hospital and Healthcare Association (VHHA), are utilizing a small-group structure within the VHHA to discuss and address issues of mutual interest and initiate joint activities in response to mutual needs. This group is called "The Behavioral Healthcare Forum". • 1999 General Assembly appropriation of $2.5 million for purchase of local in-patient care. Region IV has developed an acute care pilot project in association with Richmond Metropolitan area private providers.

	House Document 77 (HD 77) Recommendation, Resolution, and Budget Bill Language	Source & Resources	Progress Notes
HD 77 #41	The State Board and the DMHMRSAS should continue and expand efforts to involve and increase the participation of private providers in policy development, planning, service delivery, and oversight and evaluation activities.		• See Item # 40 • DMHMRSAS continues to involve all these groups in these activities - for example, the ASO Leadership Council, the POMS Work Groups, Priority Populations , the Care Management Work Group, and the Commonwealth Partnership or Women and Children Affected by Substance Abuse. • See Item # 2
HD 77 #42	The DMHMRSAS should continue to explore and, where feasible and desirable, institute or expand the provision of services by private providers at its state facilities. Such initiatives should be carefully developed, with close attention devoted to economic efficiency, effectiveness, service quality, and continuity of care criteria in making the decision of whether to contract services.		• Department staff have been involved in a number of efforts to explore and, where feasible and desirable, institute or expand the provision of services by private providers at state facilities. Areas where provision of services by private providers has been feasible, include the privatization of the pharmacies at two state mental health facilities, the provision of laboratory reference services to eight facilities and supplemental services the remaining facilities, and the establishment of a locum tenens contract to enable facilities to access physician services. The Department also contracted with a private company to staff a medium security unit at the Riverside Jail in Petersburg, thereby relieving census pressure at the CSH Forensic Unit. • DMHMRSAS has contracted with private providers for restoration of competency services for juveniles.

	e Document 77 (HD 77) Recommendation, Resolution, and Budget Bill Language	Source & Resources	Progress Notes
HD 77 #43	The DMHMRSAS should establish an informal forum of representatives from the institutions of higher education, CSBs, state facilities, and consumer and family advocacy groups to examine current and possible future roles for the academic community in the publicly-funded mental health, mental retardation, and substance abuse services system. This forum should produce a report to the Commissioner that defines the appropriate roles for colleges and universities in the publicly-funded services system. The report should also present proposals for expanding linkages between the academic community and state facilities and CSBs, particularly for the disciplines and specialties mentioned.		• $500,000 appropriated by 1999 General Assembly for university psychiatric school linkages. Psychiatrists in under served areas initiative for placement of psychiatrists in under served regions of the state. • DMHMRSAS works with KOVAR, an interdisciplinary training and recruitment program sponsored by the Knights of Columbus, to prepare students in medicine and the allied health professions to work with persons with mental retardation. The institute is taught by college and university faculty as well as practicing experts in community and facility programs. Includes consumers and family members as presenters. Students from across the U.S. participate in the institute and facility and community employees have attended some of the Institute's lectures. The institute is an intensive six week experience, and students spend their final week in a community or facility placement.
HD 77 #44	The current CSB performance contract and report mechanism should be expanded and refined by adding a focus on provider performance and consumer outcomes by July 1, 2000. These include service accessibility, quality, and appropriateness standards; inter-system performance measures; and requirements for consumer and family member participation in policy development and service planning, delivery, and evaluation. Additionally, a mechanism to measure and report on consumer satisfaction should be added to the contract mechanism.	HB 428	• Language included in SFY 2000 and draft SFY 2001 Performance Contracts to require participation in POMS.
HD 77 #45	The CSB performance contracts should be voted on by each local governing body involved in the CSB.	HB 428	• Completed

	House Document 77 (HD 77) Recommendation, Resolution, and Budget Bill Language	Source & Resources	Progress Notes
HD 77 #46	The DMHMRSAS should negotiate annual performance contracts with each state facility, similar to the performance contracts between CSBs and the Department.		• Completed. • Legislation enacted in 1999 (§ 37.1-42.2) to permit DMHMRSAS to contract with state facility directors.
HD 77 #47	Once POMS has been successfully piloted, revised, and implemented statewide, appropriate and relevant measures from it should be included in the CSB and state facility performance contracts and reports. Changes in POMs should be based on the results of the POMS pilots.	SJR 152	• Pilot project completed. • Based on the results of the pilot project, statewide data collection begins July 1, 2000 and full implementation by FY 2001. • A final report on the results of the MR/ POMS pilot is currently scheduled for April 1, 2000. Statewide implementation is to begin July 1, 2001 and be completed October 1, 2001.
HD 77 #48	The DMHMRSAS should explore the development and implementation of approaches to reward superior performance and deal with poor performance for inclusion in CSB and state facility performance contracts.		• State facility performance contracts revised. New incentive based performance programs in facilities. • Language in SFY 2000 CSB Performance Contracts to deal with performance issues.
HD 77 #49	The DMHMRSAS, the Department of Medical Assistance Services, and the CSBs should identify mechanisms to increase the consistency, uniformity, and validity of community services information, including standardized cost accounting systems and client information data bases.	HB 428	• Uniform CSB Cost Report will be implemented in SFY 2001.
HD 77 #50	The DMHMRSAS and the CSBs should jointly develop an implementation plan that describes statewide costs on a phased, multi-year basis for the full implementation of POMS and the information systems required to support it. The DMHMRSAS should report to the Governor and General Assembly prior to the 2000 Session of the General Assembly on the status of and resources required for fully implementing POMS.	SJ 152	• Report submitted November 1999.

	e Document 77 (HD 77) Recommendation, Resolution, and Budget Bill Language	Source & Resources	Progress Notes
HD 77 #51	The State Board should ensure the consolidation of all existing human rights regulations governing facilities, CSBs, and private programs into one comprehensive regulatory framework as soon as possible. Once implemented, the DMHMRSAS should review these regulations regularly to assess their adequacy in affording human rights protections.		• Regulations being revised and submitted for public comment early 2000.
HD 77 #52	The human rights program in state facilities should be strengthened and expanded to assure adequate availability, accessibility, rights protections, and resources. The DMHMRSAS should redistribute facility advocates in proportion to facility census so that each consumer has equal access to an advocate.	Budget Bill Item 341 #5c (Also see HD 77 #66) FY 1999 -- $100,000 FY 2000 -- $100,000	• Completed. The Department's Office of Human Rights Assistant Director position has been established and filled. • Facility advocate positions redistributed.
HD 77 #53	The DMHMRSAS should study the adequacy of advocate positions in the state facilities and request additional resources in the next budget cycle, if needed, to assure that each consumer has sufficient access to an advocate.		• Completed
HD 77 #54	The DMHMRSAS should remove immediately all potential for influence on human rights advocates by the state mental health and mental retardation facilities. All advocate and advocate support positions should be supported by the DMHMRSAS Central Office maximum employment level (MEL) positions and budget.		• Completed
HD 77 #55	The DMHMRSAS should require facility directors to provide adequate office space, equipment, and supplies to support all day-to-day operations of the advocates within their facilities. The DMHMRSAS should ensure that state facility directors and staff play no role in the recruitment, hiring, supervision, or training of the advocates.		• Completed and incorporated into Facility Performance Agreements.

	House Document 77 (HD 77) Recommendation, Resolution, and Budget Bill Language	Source & Resources	Progress Notes
HD 77 #56	The State Board should revise the human rights regulations to prohibit the practice of facility directors serving as authorized representatives for medical and treatment decisions for patients and residents in state facilities.		• § 37.1-84.1 revised in 1999 to prohibit practice. Addressed in draft regulations.
HD 77 #57	The DMHMRSAS should arrange for training in the areas of mental disabilities and human rights for judges who hear cases involving consent to medical and psychiatric treatment decisions.		• Information from Office of the Attorney General on alternatives to authorized representatives distributed to judges.
HD 77 #58	Decisions other than medical and treatment decisions (e.g., consent to release of records or participation in an outside activity) can continue to be made by facility directors, but only with adequate, consistent, and formal oversight by local human rights committees, and only when there is no alternative.		• Addressed in Code revisions 1999 (§37.1-84.1).
HD 77 #59	The human rights regulations should be revised to prohibit the use of seclusion and restraint for behavior modification purposes; place clear limitations on the use of seclusion and restraint for any other purpose; provide for adequate monitoring of each use of seclusion and restraint; and require that the DMHMRSAS develop, implement, and enforce a system-wide policy governing the use of seclusion and restraint.		• The prohibition against seclusion and restraint as part of behavioral plans has been incorporated into draft regulation. • Issues related to seclusion and restraint were addressed in the State Facility Clinical Guidelines. A Departmental Instruction on seclusion and restraint has been developed by DMHMRSAS.
HD 77 #60	The DMHMRSAS should study the adequacy of advocate positions in CSBs and request additional resources in the next budget cycle, if needed, to assure that consumers in CSB and other community programs have sufficient and equal access to advocates regardless of the location of the program in which they are receiving services.		• Completed. A fifth regional advocate position funded in FY 1999.

	;e Document 77 (HD 77) Recommendation, Resolution, and Budget Bill Language	Source & Resources	Progress Notes
HD 77 #61	The DMHMRSAS should be authorized to sanction programs for non-compliance with the human rights regulations. Mechanisms should include funds withdrawal, fines, and/or penalties. The DMHMRSAS should regularly monitor and enforce the human rights regulations in all public and private mental health, mental retardation, and substance abuse programs.		• Sanctions added in *Section 37.1-185.1,* 1999.
HD 77 #62	The practice of allowing CSBs and private providers to nominate persons for appointment to the Local Human Rights Committees that oversee the CSBs should be prohibited. Nominations to local human rights committees should be made through the advocates directly to the State Office of Human Rights.		• Completed. State Human Rights Committee adopted revised guidelines which have been disseminated.
HD 77 #63	The State Board should revise the human rights regulations to require CSBs and private programs to publicize, at least annually, information about the existence and purpose of the human rights program. CSBs should actively encourage interested citizens to contact the regional advocate for potential appointment to Local Human Rights Committees whenever there is a vacancy.		• This recommendation has been incorporated in the draft regulation.
HD 77 #64	The DMHMRSAS and the State Human Rights Committee should implement a procedure to ensure inclusion of adequate consumer and family representation on all Local Human Rights Committees.		• Code changes enacted in 1999 (§ 37.1-84.3) to require representation. The State Human Rights Committee has developed new guidelines. Additionally, an assessment of the composition of all Local Human Rights Committees was completed and the SHRC uses this information to carefully scrutinize all nominations for appointments to local committees to ensure inclusion of consumers and family members.

	House Document 77 (HD 77) Recommendation, Resolution, and Budget Bill Language	Source & Resources	Progress Notes
HD 77 #65	The human rights regulations should be revised to require consolidation of CSB, private provider, and facility Local Human Rights Committees into regional committees wherever appropriate and feasible, in order to strengthen membership, assist in recruitment, and promote consistency in decision-making. The DMHMRSAS should provide training to Local Human Rights Committees at least annually and should reimburse expenses incurred in carrying out their duties in accordance with state travel regulations.		• The Department's Office of Human Rights, in conjunction with the State Human Rights Committee, is currently assessing the number of local human rights committees required to adequately address consumer needs. • Training is ongoing, with at least four training sessions conducted in each region annually. • Correspondence was sent to programs regarding reimbursement of LHRC members. The Department's Office of Human Rights monitors implementation.
HD 77 #66	The DMHMRSAS should provide statewide educational seminars on annual basis for Local Human Rights Committee members and any other interested persons, on a cost basis for participants if funding is not otherwise available.	Budget Bill Item 341 #5c (Also see HD 77 #52)	• The Human Rights Seminar was held in October 1998. This training was provided at no cost to LHRC members. (See Item # 52).
HD 77 #67	The DMHMRSAS should conduct a thorough review and revision of the current Departmental Instruction on reporting and investigating allegations of abuse, redouble efforts to require all facilities to abide strictly by the terms of the statewide policy, prohibit the development of alternative facility policies, and monitor and affirmatively enforce the statewide policy. Minimally, the statewide policy should provide that investigations into all allegations of abuse and neglect be conducted by highly trained and skilled neutral investigators who have no interest in the outcome of the investigation. The policy should be regularly reviewed and revised to assure its maximum effectiveness.		• Departmental instruction revised.

	se Document 77 (HD 77) Recommendation, Resolution, and Budget Bill Language	Source & Resources	Progress Notes
HD 77 #68	CSBs and private programs should be required to develop policies governing prevention, detection, reporting, and suspension of employees, and investigation and follow-up on all allegations of abuse or neglect, with such policies subject to the review and approval of the DMHMRSAS Commissioner. CSBs and private programs should be required to report to the DMHMRSAS Office of Human Rights all allegations of abuse or neglect.		• Addressed in 1999 Code changes (§ 37.1-84.1).
HD 77 #69	All programs providing services to persons with mental disabilities should be authorized statutorily to access information about potential employees' criminal convictions of violent crimes or past abusive acts in other programs and to provide such information concerning their own employees. A central registry should be established. Immunity should be provided for program personnel who share information about current or past employees. The DMHMRSAS should examine the availability and utility of other mechanisms to assist in screening out potential employees who are likely to abuse consumers.	HB 1293 (Carried Over) HB 2572 Enacted - 1999	• Legislation effective July 1, 1999 • Central Registry not established.
HD 77 #70	The DMHMRSAS should study the issues involved in the employee grievance procedure to develop solutions for prohibiting the reinstatement to work of facility employees who are terminated for acts of abuse or neglect.	SB 1302, 1999	• Legislation enacted to authorize DERC to review hearing officer's decision for consistency with law.
HD 77 #71	The DMHMRSAS should assure that adequate human rights oversight mechanisms are built into any managed care system, including clearly articulated and enforced human rights standards, immediate advocate access, and an effective appeals mechanism for handling complaints from denials of care or treatment.	HJR 278	• The development of educational materials describing human rights standards and oversight mechanisms is in process. • Educational materials will be developed as needed.

	House Document 77 (HD 77) Recommendation, Resolution, and Budget Bill Language	Source & Resources	Progress Notes
HD 77 #72	The DMHMRSAS should develop and implement statewide standards of care for the state facilities and for CSB programs.		• Ongoing through the development of State Facility Clinical Guidelines. • New Departmental Instructions address a number of topic areas, including state facility admissions and discharges, active treatment/services and supports, medical/surgical care, DNR orders, psychopharmacology, behavior management, seclusion and restraint, patient/resident leave practices, medical/clinical records, client abuse and neglect, quality assurance and quality improvement, risk management, staffing levels, and competency-based staff training and development • Development of CSB standards planned in FY 2001.
HD 77 #73	The DMHMRSAS should design and implement a modern, reliable, current, and effective data collection system for human rights information.	Budget Bill Item 341 #1c FY 1999 -- $180,000 FY 2000 -- $7,000	• Comprehensive Human Rights Information System (CHRIS) will be implemented by July 1, 2000.
HD 77 #74	The DMHMRSAS should provide the resources necessary to provide appropriate oversight of the internal human rights program.		• The redistribution of resources and establishment and recruitment of additional positions have resulted in continuous improvement in operations.
HD 77 #75	The State Board, State Human Rights Committee, the Commissioner and the State Human Rights Director should make a continuous effort to review and assess the effectiveness of the internal human rights system and make improvements where needed. Interaction and communication among these entities should increase.		• Ongoing. Increased involvement and communications with the Department for Rights of Virginians with Disabilities, the Virginia Alliance for the Mentally Ill (VAMI), and other external advocacy entities.

	;e Document 77 (HD 77) Recommendation, Resolution, and Budget Bill Language	Source & Resources	Progress Notes
HD 77 #76	The most effective structure and location of an external human rights protection system in Virginia should be studied. The study should explore whether an external system located within the executive branch of state government can adequately protect consumers and whether placement in the judicial branch of government would better serve consumers. The DMHMRSAS, the State Board, DRVD, the PAIMI Council, the Board for People with Disabilities, the Supreme Court and representatives from consumer and advocacy groups, CSBs, and private providers should be included in the study.	HJR 225 HB 2414 and HB 1224 1999	• Recommendation of HJR 225, 2000. Studied by Human Rights Workgroup.
HD 77 #77	The current practice of providing Medicaid SPO and Waiver match through transfers from CSB appropriations should be ended. Match funds should be appropriated in the DMAS budget, as is the case for all other health care providers in the Commonwealth.	HJR 225	• No Department action is required. • HJR 225 Medicaid Work Group developed proposal.
HD 77 #78	State general funds currently being used by CSBs to match Medicaid dollars should be restored to the CSBs to provide individualized packages of services and supports to people who have been identified as ready for discharge from state facilities or who are on waiting lists in communities.	Not Funded	• No Department action is required.
HD 77 #79	The DMHMRSAS should identify those CSBs that have not converted and expanded Medicaid Services. The performance contract and future level of state funding to CSBs should be adjusted to reflect, to the extent possible, a comparable degree of effort to convert existing services to Medicaid and to expand Medicaid-funded services.		• Department staff are working with CSB's that have not converted existing services to Medicaid or expanded Medicaid-funded services to maximize their use of available Medicaid resources. • Targets were set in FY 1999 Performance Contracts for CSB's with under 25% conversion.

	House Document 77 (HD 77) Recommendation, Resolution, and Budget Bill Language	Source & Resources	Progress Notes
HD 77 #80	The DMHMRSAS and DMAS should continue to review and expand Medicaid covered services for mental health, mental retardation, and substance abuse services as a budget and service policy to insure the maximum use of federal funds available for individuals eligible for Medicaid.	Budget Bill Item 341 #11c Report to: Governor, Chairmen of House Approp. and Senate Finance Committees and HJR 240 Joint Subcommittee	• MR Waiver Study, HD 61, 1999. • Medicaid coverage for Substance Abuse Report submitted October 1999.
HD 77 #81	The DMHMRSAS should develop and implement a funding mechanism that reallocates a reasonable proportion of resources saved through state facility bed reductions to CSBs where patients or residents will return and incorporates managed care utilization review and management practices, provided the facility meets appropriate standards of quality.	HJR 113	• Region IV Acute Care Pilot incorporates managed care utilization management practices. • Bed reduction savings directed to improving staffing ratios at state facilities.
HD 77 #82	The Joint Subcommittee should present recommendations prior to the 2001 Session of the General Assembly on implementation of the carve-out which would be effective July 1, 2001.	HJR 212	• Addressed by Medicaid Workgroup recommendation of HJR 225, which proposed a partial carve-out in its final report.

	Document 77 (HD 77) Recommendation, Resolution, and Budget Bill Language	Source & Resources	Progress Notes
HD 77 #83	The Department of Social Services (DSS) and the DMHMRSAS should develop pilot projects in areas that have high concentrations of ACRs. The pilot projects should determine and provide the appropriate treatment and supports for persons with mental illness, mental retardation, or substance abuse problems who reside in ACRs. The DSS and DMHMRSAS should submit a report to the House Appropriations and Senate Finance Committees on the pilot projects prior to the 1999 Session of the General Assembly.	Budget Bill Item 347#12c FY 1999 -- $750,000 FY 2000 -- $750,000 Report to: Chairmen of House Approp. and Senate Finance Committees	• Pilots ongoing. • Report submitted January 2000.
HD 77 #84	The Secretaries of Administration, Commerce and Trade, and Health and Human Resources should study the feasibility of creating a residential alternatives capital fund to address the housing needs of persons with mental disabilities and substance abuse problems. The Secretaries shall complete their study and report to the House Appropriations and Senate Finance Committees prior to the 1999 Session of the General Assembly.	SJR 159	• Report incorporated with study pursuant to SJR 456. Senate Document 12, 2000.
HD 77 #85	The Department of Health, in cooperation with DMHMRSAS, should conduct a comprehensive assessment of the primary health care needs of persons with mental illness, mental retardation, or substance abuse problems. The assessment should include a review of patients and residents in state facilities and persons served by community services boards. The needs assessment should be presented to the Governor and General Assembly prior to the 1999 Session of the General Assembly.	SJR 154	

	House Document 77 (HD 77) Recommendation, Resolution, and Budget Bill Language	Source & Resources	Progress Notes
HD 77 #86	As part of a comprehensive long-range plan for addressing the increasing aging population, the DMHMRSAS and DMAS should explore the feasibility of providing a supplement to private nursing homes and other alternatives to expand community-based services for elderly individuals with mental disabilities. This plan should be presented to the Governor and General Assembly prior to the 1999 Session of the General Assembly.	Budget Bill Item 342 1999	• Included in Master Plan requirements, 1998.
HD 77 #87	Atypical antipsychotic medications should be the first line of treatment for persons with serious mental illness in state facilities and community programs.	Budget Bill Item 346 #1c Item 347 #9c	• Completed
HD 77 #88	The DMAS should be directed to mandate the availability of atypical antipsychotic medications on all formularies used by Medicaid managed care companies (e.g., HMOs) in Virginia.		• HJR 225 recommendation.
HD 77 #89	The DMHMRSAS and the CSBs should establish intensive and assertive community treatment teams in communities with the highest usage of state mental health facility beds per 100,000 population. The DMHMRSAS should establish targets to reduce state facility bed utilization as these teams become operational.	Budget Bill Item 347 #7c	• Ongoing. • 11 PACT teams in operation statewide, plus Henrico PACT team developed locally.
HD 77 #90	In a managed care environment, the DMHMRSAS, DMAS, and CSBs should ensure that psycho-social rehabilitation services continue to be available for consumers.		• Ongoing.
HD 77 #91	The Department of Rehabilitative Services and the DMHMRSAS should work together to address the employment needs of persons with serious mental illness [mental retardation and substance abuse problems]. The agencies shall report to the 1999 Session of the General Assembly on their findings.	SJR 151 Report to: Governor and General Assembly	• Report submitted, SD 14, 1999. • $1.4 million of state funds and federal Substance Abuse Prevention and Treatment Block Grant (SAPT) funds have been allocated in a joint project with DRS to expand employment opportunities for SA consumers.

	Document 77 (HD 77) Recommendation, Resolution, and Budget Bill Language	Source & Resources	Progress Notes
HD 77 #92	The DMHMRSAS and the Department of Rehabilitative Services should develop an action plan for the appropriate treatment of persons with acquired brain injuries in the mental health system and present it to the 1999 Session of the General Assembly.	SJR 158 Report to: Governor and General Assembly	• Report submitted, SD 16, 1999.
HD 77 #93	The DMHMRSAS should enhance and better coordinate facility and community services for persons who deaf or deaf and blind and have mental disorders. The special unit for the deaf and deaf-blind at Western State Hospital should not be included in plans for downsizing.	Budget Bill Item 347 #13c FY 1999 -- $200,000 FY 2000 -- $200,000	• Statewide coordinator hired at DMHMRSAS. • 2 Additional regional coordinators hired. • Expansion of interpreter pool funds complete.
HD 77 #94	The State Board and DMHMRSAS should ensure that the service needs of children with or at risk of severe emotional disturbance are a primary consideration in the development and implementation of priority populations.		• Part of priority populations definitions and classification forms developed by DMHMRSAS.
HD 77 #95	The Health Department should continue to be responsible for primary prevention strategies that target mental retardation. These activities should occur in collaboration with CSB efforts that address primary prevention activities related to alcohol and substance abuse. In addition, the Health Department should be responsible for developing and monitoring specific goals, strategies, and outcomes addressing the prevention of mental retardation in collaboration with the local coordinating councils for prevention.		• No Department action is required.

	House Document 77 (HD 77) Recommendation, Resolution, and Budget Bill Language	Source & Resources	Progress Notes
HD 77 #96	A new plan for early intervention services should be developed by the Virginia Interagency Coordinating Council and the Local Interagency Coordinating Councils. It should emphasize more aggressive outreach efforts to identify more unserved infants and toddlers, and it should include expanded state support and increased use of Medicaid as a funding source.		• Report and plan completed and submitted to Secretary of HHR , October 1998. • Department developed an RFP for a statewide public awareness campaign to increase identification of unserved infants and toddlers. • Number of infants and toddlers have continued to increase annually. 87% increase in children identified in FY 2000. • DMHMRSAS and DMAS working to increase coverage of early intervention services through several collaborative efforts. • Identified issues presented to Joint Subcommittee on Early Intervention (HJR 725).
HD 77 #97	The DMHMRSAS, DMAS, and CSBs should maximize Medicaid funding for mental retardation services. A target should be an amount equivalent to at least 75% of the current state general funds which support community mental retardation services being used as Medicaid match.		• Department staff are working with CSB's that have not converted existing services to Medicaid or expanded Medicaid-funded services to maximize their use of available Medicaid resources. • Targets were sent in FY 1999 Performance Contracts for CSB's with under 25% conversion.
HD 77 #98	The DMAS, DMHMRSAS, and the mental retardation field should to work together to develop a more inclusive Waiver that reimburses flexible and informal supports.	Budget Bill Item 341 #10c Report to: Governor and Chairmen of House Appro. and Senate Finance Committees	• Report submitted, HD 61, 1999.
HD 77 #99	Once the priority populations pilot projects are completed and the necessary legislation and policies have been passed, state general funds should be allocated for any consumer found to meet the highest priority emergency need category through the priority population assessment process.		• No action is required until priority populations are finalized. See recommendations #8 and #17.

	se Document 77 (HD 77) Recommendation, Resolution, and Budget Bill Language	Source & Resources	Progress Notes
HD 77 # 100	The majority of State general funds should be allocated to CSBs on the basis of service rates with funding tied to individualized service plans. (ISP's)		• Ongoing • Individually funded discharges for targeted long-stay patients is ongoing at state adult psychiatric hospitals.
HD 77 # 101	The DMHMRSAS and the CSBs should implement five pilot projects: • Housing Development Pilots • Mobile Community Crisis Stabilization Team Pilots • Alternative Community Facilities for Medically Fragile Children • Center for Developmental Medicine/Ancillary Services • Regional Emergency Management Funds	Not Funded	• No Department action required because these projects were not funded.
HD 77 # 102	The General Assembly should affirm a strong substance abuse policy for the Commonwealth and provide resources to increase capacity and reduce waiting lists for persons who need substance abuse treatment services.	HJR 254	• See Item # 103. Council members have been appointed by the Governor.
HD 77 # 103	The Governor's Council on Alcohol and Drug Abuse Problems should be reconstituted as the Substance Abuse Services Council and its powers and duties should be redefined. The twenty-two members of the new Council should include the heads of agencies that receive substance abuse funding and representatives of local government, community services boards, the Virginia Sheriff's Association, the General Assembly, consumer and advocacy organizations, and statewide provider associations.	HB 1292	• Council appointed. • An information packet has been forwarded to members to prepare for their first meeting.

	House Document 77 (HD 77) Recommendation, Resolution, and Budget Bill Language	Source & Resources	Progress Notes
HD 77 # 104	The recommendations of the Crime Commission's study (HJR 443, 1997) concerning alcohol and other drug screening and assessment for offenders should be adopted and implemented.	HJR 157	• Governor's Substance Abuse Reduction Effort (SABRE) addresses problems associated with illegal drug use. It is a five point program of enforcement, treatment, and prevention that targets drug dealers as well as casual and chronic drug users. One of the five program elements will establish a screening and assessment process that is intended to divert selected offenders with substance abuse problems from the traditional sanctions of jail and prison sentences. Legislation passed in 1999 (HB 2159 and SB 1077) initiated pilot projects beginning July 1, 1999, with statewide implementation beginning January 1, 2000.
HD 77 # 105	The General Assembly should establish drug courts in those judicial circuits that express interest that have high drug offense case dockets and sufficient correctional and treatment services to support the drug court.	SJR 156	• The state has 8 localities with drug courts in the operational stage. Six of these serve circuit courts in Richmond, Norfolk, Roanoke, Charlottesville, Newport News, and Fredericksburg. Two serve juvenile courts in Richmond and Fredericksburg. • Four localities have federally funded planning grants: Va. Beach, Newport News, Chesterfield/Colonial Heights, and Portsmouth. Two localities ae in the planning stages: Danville and Chesapeake. • SJR 399 agreed to in 1999 requested DCJS to study structural, funding and service guidelines for Va's drug court programs. This study will provide recommendations on expansion of the drug court programs.
HD 77 # 106	An incentive fund should be established to develop innovative local programs to treat offenders.		• Governor's SABRE initiative. See Item # 104.
HD 77 # 107	The Virginia Council on Coordinating Prevention should be fully implemented and strengthened.	HB 1294	• Council inactive.
HD 77 # 108	All local agencies that receive prevention funding should be required to participate in local planning and advisory groups. Ten prevention projects should be established to demonstrate the effectiveness of research-based prevention strategies.	SJR 157 Projects not funded	• Not funded. • DMHMRSAS requires CSBs through Performance Contracts to complete prevention plans in order to receive SAPT Block Grant funding.

	;e Document 77 (HD 77) Recommendation, Resolution, and Budget Bill Language	Source & Resources	Progress Notes
HD 77 # 109	The Department of Education should be requested to administer a youth risk-behavior survey.	HJR 114	• DMHMRSAS and DOE have sent a joint letter to school division superintendents requesting cooperation in the administration of the Va. Community Youth Survey, a survey of youth risk behavior. The Va. Community Youth Survey will be administered in the Spring of 2000.
HD 77 # 110	The [DMHMRSAS in cooperation with the] Department of Medical Assistance Services should be requested to study the costs and benefits of expanding Medicaid reimbursement for substance abuse services.	Budget Bill Item 341 #11c Report to: Governor and Chairmen of House Approp. and Senate Finance Committees	• Report submitted, October 1999.
HD 77 # 111	Further study should be made of the integration of welfare reform and substance abuse policy to determine what treatment programs will improve the functioning and employability of Virginia Initiative for Employment Not Welfare (VIEW) participants.	HJR 225	• DSS and DMHMRSAS conducted study. Agreed to fund (5) special projects - Norfolk, Richmond, Roanoke, Harrisonburg and Staunton. Projects to develop special services for hard to serve women who are pregnant or of child bearing age. • Final Report submitted, December 1999.
HD 77 # 112	The General Assembly should establish a Behavioral Healthcare Commission or continue the joint subcommittee to conduct further analysis of the issues and provide oversight for implementation of the recommendations.	HB 225 SB 494	• No Department action required.
BB	Mental health census reduction -- funds to discharge 85 stabilized patients with co-occurring mental illness and mental retardation.	Budget Bill Item 347 FY 1999 -- $1,584,519 FY 2000 -- $3,803,529	• MR/MH Census Reduction Funds: • Ongoing with FY 2000 funds.

	House Document 77 (HD 77) Recommendation, Resolution, and Budget Bill Language	Source & Resources	Progress Notes
BB	Continue *Keeping Our Kids At Home* program in the Roanoke Valley to contacts with community providers for short-term crisis hospitalization of children and adolescents.	Budget Bill Item 347 #3c FY 1999 -- $143,500 FY 2000 -- $143,500 Report to: Chairmen of House Approp. and Senate Finance Committees	• Report submitted October 1, 1999.
BB	New and expanded community mental health, mental retardation, and substance abuse targeted services.	Budget Bill Items 347 #2c, #7c, #8c, #11c, #12c, #13c, #14c, #15c	• Funds for targeted services were incorporated in the CSB Performance Contracts.
BB	Part H Early Intervention Provider Study	Budget Bill Item 347 #22c	• The work plan has been approved. The Cultural Diversity Specialist (30 hour contract position), was hired on 9/15/98, to begin implementation of the recommendations of the Subcommittee Studying Early Intervention Services. The specialist held the first meeting with representatives from Historically Black Colleges and Universities and others in the higher education field to address the recommendations and strategies for ongoing pre-service and in-service training, recruitment and retention of personnel from under-served groups on 10/16/98. A report from the Cultural Diversity Advisory Committee was presented to the HJR 725 Joint Subcommittee on Early Intervention on 12/10/99.

	Document 77 (HD 77) Recommendation, Resolution, and Budget Bill Language	Source & Resources	Progress Notes
BB	Continue Northern Virginia Training Center provision of medical, dental, and other related support services to profoundly mentally retarded consumers of the Northern Virginia CSBs.	Budget Bill Item 372 #1c FY 1999 -- $250,000 FY 2000 -- $250,000 Report to: Chairmen of House Approp. and Senate Finance Committees	• Report submitted, January 2000.

APPENDIX VI-4

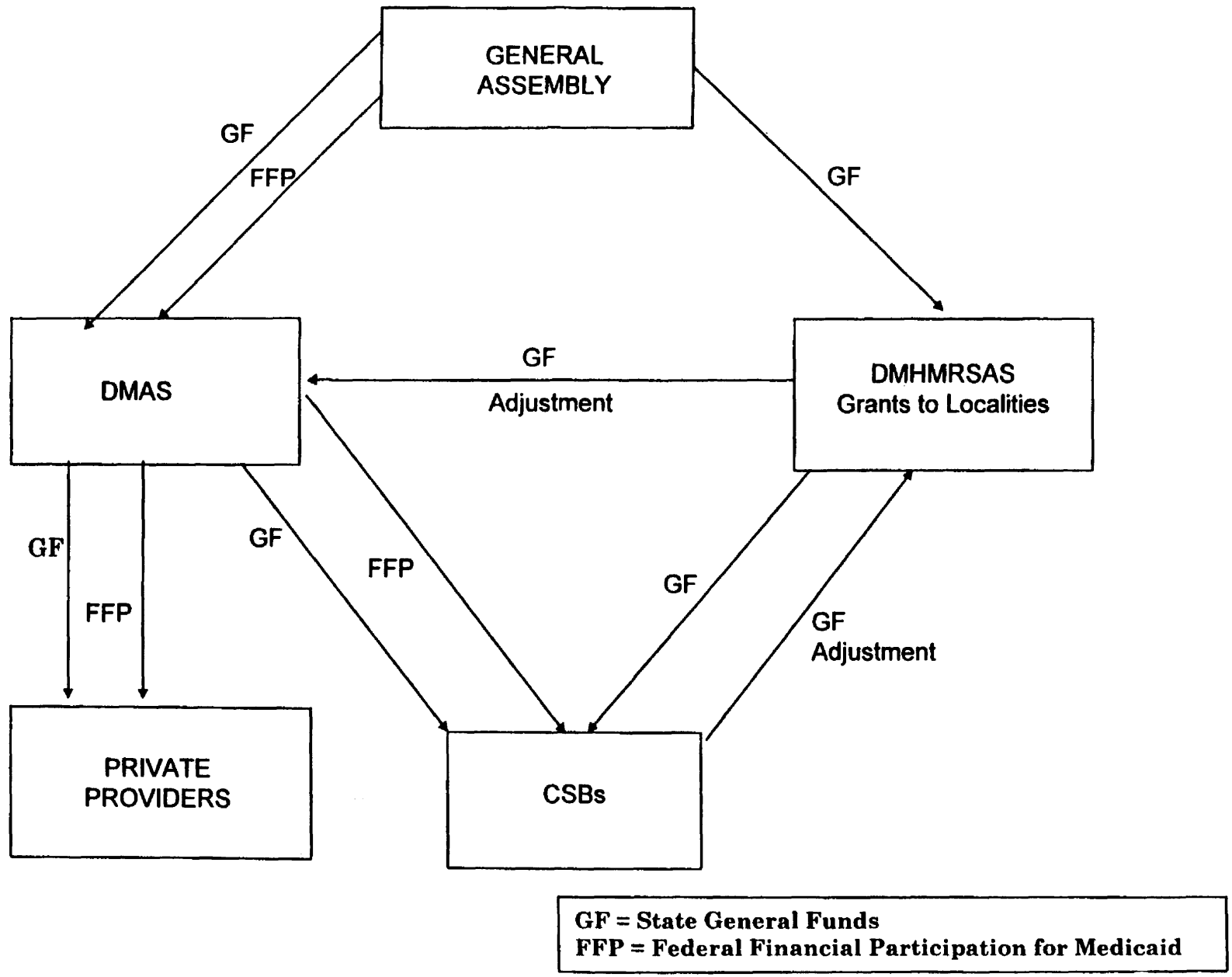
Joint Subcommittee Studying the Future Delivery of Publicly Funded Mental Health, Mental Retardation and Substance Abuse Services (HJR 225)

General Assembly
Commonwealth of Virginia

Medicaid Financing of Mental Health, Mental Retardation and Substance Abuse Services

Options for Structure and Administration
Medicaid Work Group
September 9, 1999

Model I - Current Situation

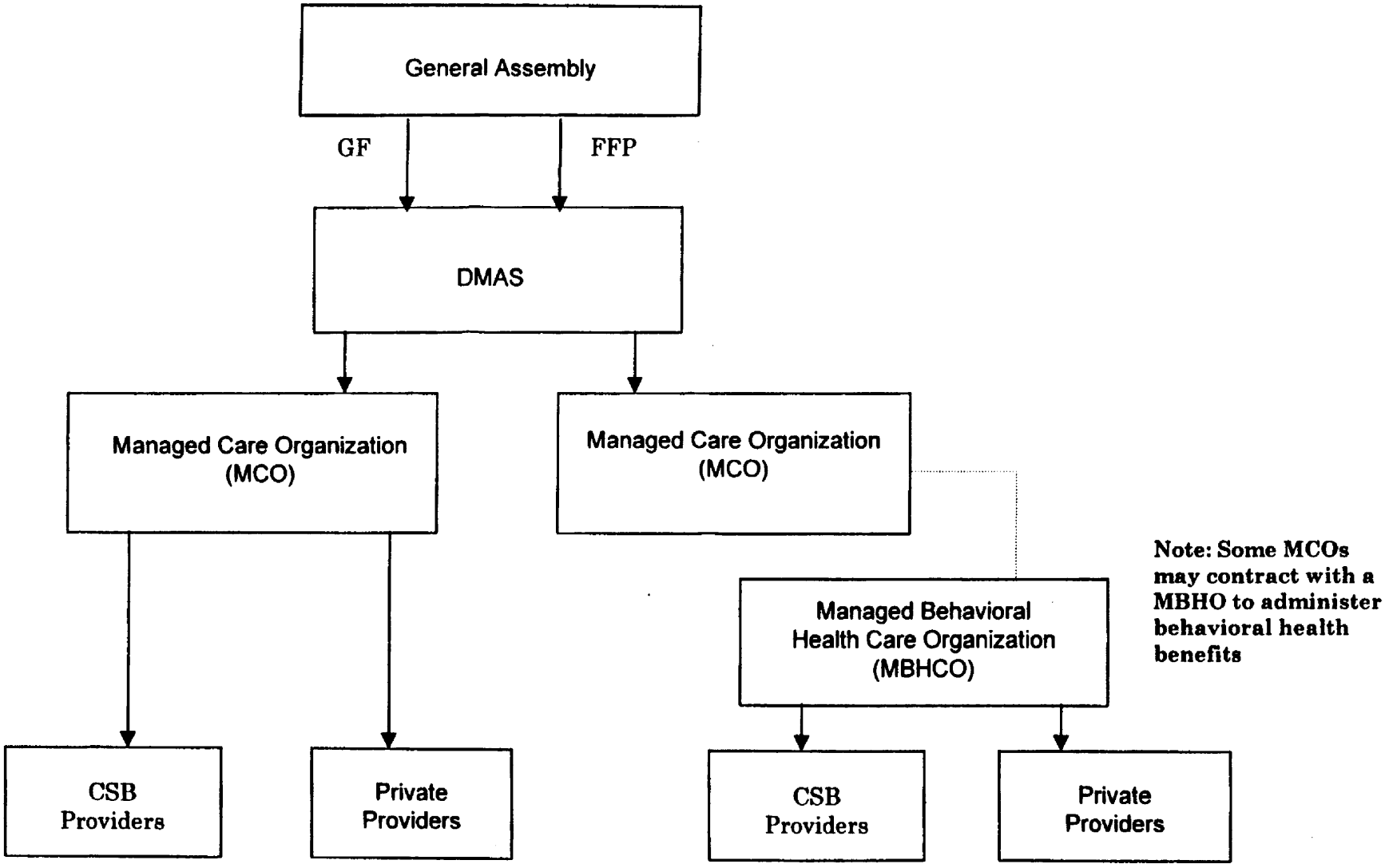


Model I - Current Situation

DESCRIPTION	ADVANTAGES	DISADVANTAGES
Mental Health • Fee-for-service • Base projection for mental health community rehabilitation services (State Plan Option--SPO) is included in DMAS biennium budget. Language in the budget (Item 335, C.2) targets specific general funds and federal trust funds for SPO services. • General funds are also appropriated to DMHMRSAS for community mental health services. From this appropriation, DMHMRSAS allocates state general funds to CSBs, some of which will be used to match Medicaid FFP. • DMHMRSAS projects CSB Medicaid revenue from historical claims. • CSBs submit claims to DMAS for reimbursement. • If CSB claims exceed base projections at DMAS, general funds from the allocation to CSBs are transferred to DMAS as match for federal financial participation Federal Financial Participation (FFP). Mental Retardation • Care management and case management; fee-for-service; service pre-authorization, utilization review and reconciliation • Separation of functions in DMHMRSAS (8/1/99): waiver financial management is organizationally separated from service preauthorization and utilization review • Base projection for community mental retardation services (MR Waiver) is included in the DMAS biennium budget. Language in the budget (Item 335, C.2) targets specific general funds and federal trust funds for the MR Waiver and SPO community mental retardation services **(continued on next page)**	1. Known system 2. Controls on general fund costs 3. Supports local infrastructure and local control over service delivery	1. Limited consumer choice, limited provider availabililty 2. Restrictions on access to services because of limited state match 3. Complex administration, involving transfer of funds between agencies 4. Fragmentation of Medicaid-covered services, e.g. mental health outpatient is separate from SPO services 5. Fragmentation of Medicaid and non-Medicaid services and consumers who need publicly funded mental health, mental retardation and substance abuse services

DESCRIPTION	ADVANTAGES	DISADVANTAGES
• General funds are also appropriated to DMHMRSAS for community mental retardation services. From this appropriation, DMHMRSAS allocates state general funds to CSBs, some of which will be used to match Medicaid FFP. (New funding is managed in the central office; CSBs do not receive general fund transfers but are assigned "match credits" against which they can draw for services to individual consumers). • CSBs apply for waiver slots and service authorizations for individual consumers. • DMHMRSAS assures that match funds are available for waiver services on a continuing basis and transfers the match to DMAS. • CSBs and private providers submit claims to DMAS up to service authorization levels. • For new funds appropriated during the 1998-2000 biennium, DMHMRSAS monitors utilization according to individual plans of care and reconciles funds to actual service delivery by CSBs.		

M. . II - Commercial Managed Care

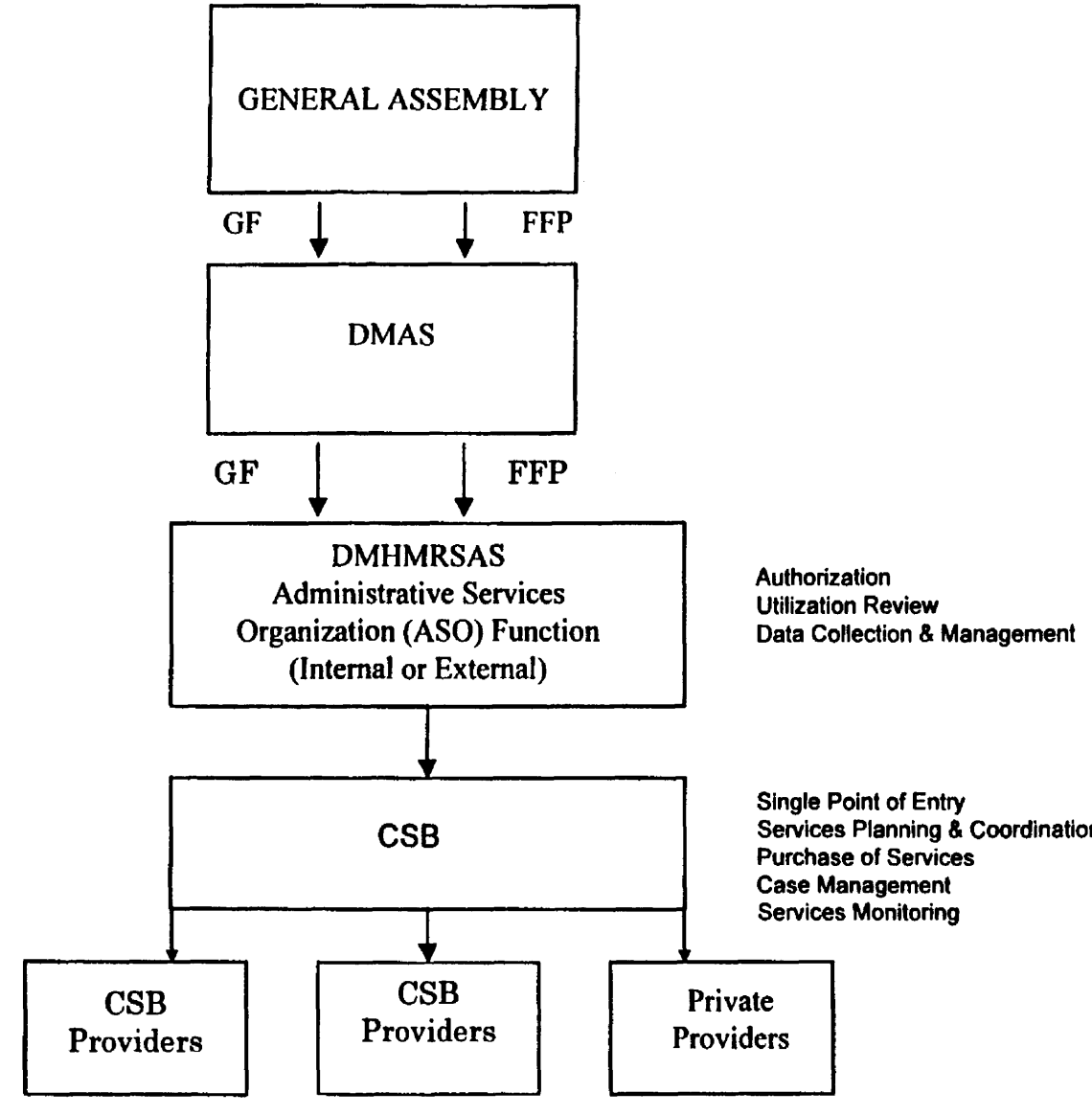


Model II - Commericial Managed Care

DESCRIPTION	ADVANTAGES	DISADVANTAGES
Mental Health • Commercial managed care organization assumes risk; capitation payments. • General funds and FFP would be appropriated to DMAS, based on DMAS cost projections. • DMAS issues an RFP and enters into contracts with primary care managed care organizations. • Managed care organizations (MCO) may subcontract with managed behavioral health care organizations (MBHCO) for behavioral health services. • MCOs and MBHCOs would be required to include CSBs on provider lists.	1. Potential for integrating behavioral health with physical health care 2. Consumer choice of managed care organizations 3. Increased access by eliminating state match barrier 4. Quality enhancements and cost-savings from managed care technology 5. Promotes competition among managed care organizations to increase consumer responsiveness 6. Limits financial exposure of DMAS to control rate of cost increases 7. Single source to coordinate Medicaid services 8. Potential for less cost shifting to medical services provided by affiliated MCO.	1. Fragmentation between Medicaid and non-Medicaid consumers and services 2. Fragmentation of Medicaid mental health services from long-term supports, including housing and community supports, and mental retardation and substance abuse services 3. DMHMRSAS uninvolved in process 4. Potentially negative effect on local infrastructure. For seriously mentally disabled adults and SED children, the ability to coordinate services across human service agencies might be weakened. 5. Unknown level of interest by MBHCOs 6. Potentially higher costs, compared to current system, that may or may not be offset by managed care technology (e.g. increased access, managed care organization fees) 7. Potential for more complexity in administration resulting from MCO/MBHCO combination 8. Concerns about potential cost shifting to state facilities, reduced levels of service, and fewer service dollars

Model III Managed Behavioral Health Care

DMHMRSAS as Subcontractor

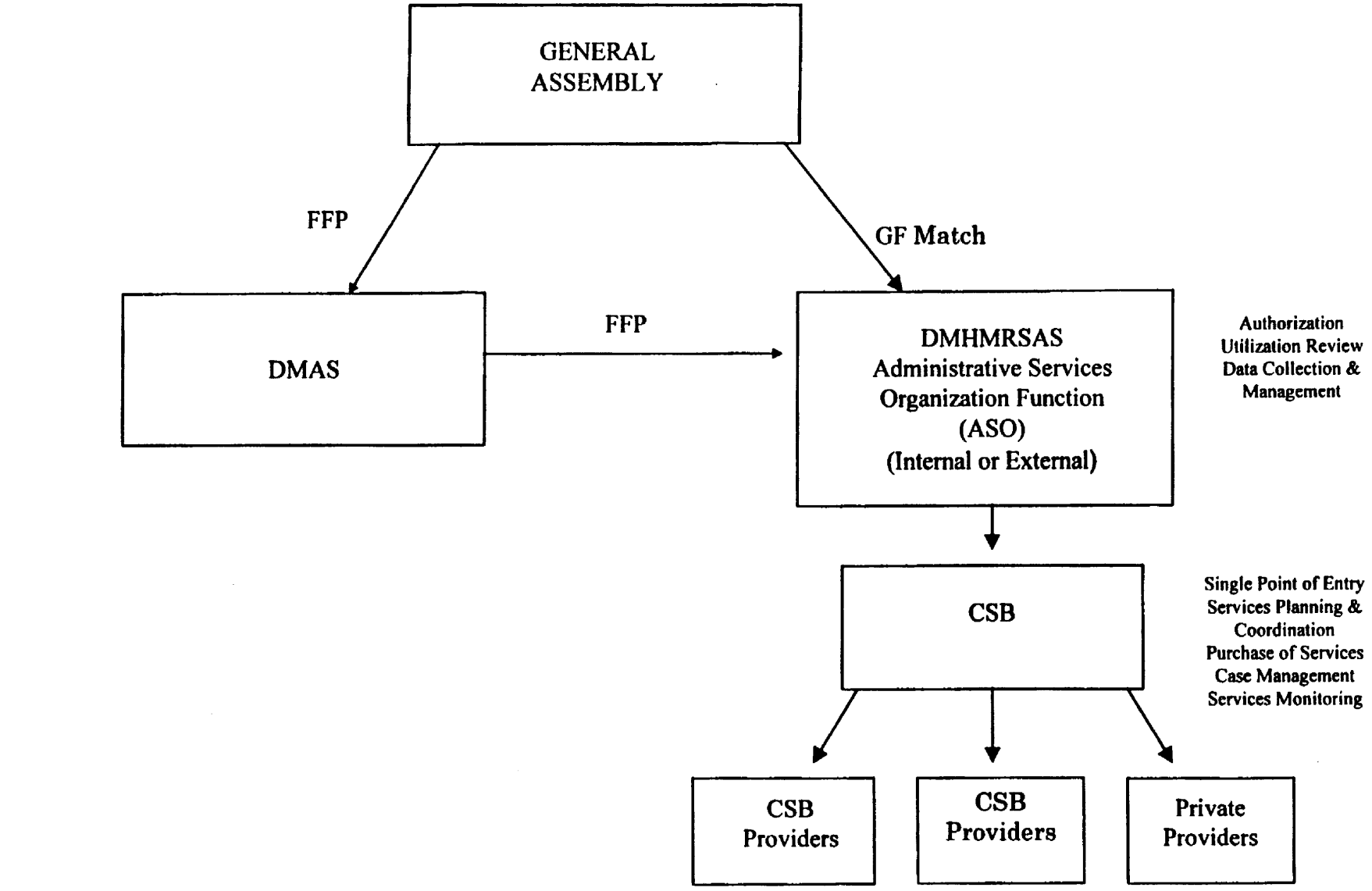


GF = State General Funds
FFP = Federal Financial Participation for Medicaid

Model III - Managed Behavioral Health Care–DMHMRSAS as Subcontractor

DESCRIPTION	ADVANTAGES	DISADVANTAGES
Mental Health, Mental Retardation and Substance Abuse Services • DMAS is the single state agency for Medicaid. • FFP and state match are appropriated to DMAS. • DMAS subcontracts with DMHMRSAS for administration of Medicaid-covered mental health, mental retardation and substance abuse services. • DMHMRSAS, working through an internal or external administrative services organization (ASO), procures services from CSBs and private providers, based on individual plans of service. • CSBs would function as care managers and single point of entry. • Consumers would have a choice among CSB service providers and private providers.	1. Integrated system for funding and delivering Medicaid and non-Medicaid community behavioral health services 2. More choice and access 3. DMHMRSAS in policy decision-making role 4. Quality enhancements and cost-savings from managed care technology	1. Lack of integration with physical health care 2. Potential duplication of administrative services between DMAS and DMHMRSAS (e.g. claims processing, utilization review) 3. Potentially higher costs, compared to current system, which may or may not be offset by system efficiencies

Mouel IV - Managed Behavioral Health Care Carve-Out



GF = State General Funds
FFP = Federal Financial Participation for Medicaid

Model IV - Managed Behavioral Health Care Carve-Out

DESCRIPTION	ADVANTAGES	DISADVANTAGES
Mental Health, Mental Retardation and Substance Abuse Services • DMAS is the single state agency for Medicaid. • DMAS and DMHMRSAS would sign an interagency agreement, detailing their specific roles and responsibilities. • FFP would be appropriated to DMAS; general fund match for SPO and MR waiver would be appropriated to DMHMRSAS with specific budget language. • DMHMRSAS, working through an internal or external administrative services organization (ASO) would procure services from CSBs and private providers, based on individual plans of care. • CSBs would function as care managers and single point of entry. • Consumers would have a choice among CSB service providers and private providers.	1. Integrated system for funding and delivering Medicaid and non-Medicaid community behavioral health services 2. More consumer choice and access because of oversight and elimination of state match barrier 3. Integrated policy responsibility at the state level for behavioral health services 4. Single point of accountability 5. Quality enhancements and cost-savings from managed care technology 6. Assurance that appropriated funds would be used for designated purpose	1. Lack of integration with physical health care 2. Potential duplication of administrative services between DMAS and DMHMRSAS 3. Potentially higher costs, compared to current system, that may or not be offset by system efficiencies 4. Time and other resources required on the front end to develop the interagency agreement and necessary controls that DMAS requires as the single state agency for Medicaid

APPENDIX VI-5

HJR 225 Medicaid Work Group

Medicaid Structure and Administration Options

Alternative Model III

Revised Staff Discussion Paper

December 16, 1999

A. Introduction

1. The Medicaid Work Group of the Joint Subcommittee Studying the Future Delivery of Publicly Funded Mental Health, Mental Retardation, and Substance Abuse Services (HJR 225) has identified four models for the structure and administration of Medicaid-funded services in the future. Model I would leave the status quo in place. Model II would result in a full carve in of behavioral health services into the Medicaid Medallion II managed care program. Current State Plan Option and Waiver services would be included in at risk capitated managed care contracts with HMOs and MCOs. In Model III, the Virginia Department of Medical Assistance Services (DMAS) would subcontract the administration of all Medicaid behavioral health services to the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS). Model IV would be a full carve out of all behavioral health services from Medicaid, including Medallion II, to DMHMRSAS. It is important to note that, regardless of the model selected, DMAS must continue to be the single state agency that is by federal law responsible to the federal Health Care Financing Administration (HCFA) for the operation of the medical assistance program funded under the Social Security Act in Virginia.

2. To many constituents of Virginia's mental health, mental retardation, and substance abuse services system, a full carve-out (Model IV) may ultimately be the most desirable structural option; but daunting regulatory, policy, and operational details, while not necessarily insurmountable, could delay implementation of this option for years.

3. Model III is an intermediate option that requires DMAS to subcontract with the DMHMRSAS for administration of certain Medicaid-covered mental health, mental retardation and substance abuse services. Model III could move the services system to Model IV in the future with less disruption.

4. Therefore, Model III, a partial carve-out, is the more immediately feasible and desirable option, perhaps as an interim step to achieving a full carve-out.

B. Model III Clarifications

1. This revised staff discussion paper expands on and clarifies some aspects of Model III, as it appeared in the initial staff briefing materials presented to the HJR 225 Joint Subcommittee Medicaid Work Group. This revised paper also responds to some of the concerns expressed by DMAS and others about the original Model III.

2. Model III applies only to Medicaid State Plan Option, MR Home and Community-Based Waiver, and any other new or expanded mental health, mental retardation, and substance abuse services related to these SPO and MR Waiver services subsequently added to the list of covered Medicaid services. For purposes of this paper and Alternative Model III, State Plan Option (SPO) services mean community mental health rehabilitation services, targeted mental health and mental retardation case management, substance abuse treatment for pregnant and postpartum women and intensive in-home and therapeutic day treatment for children and adolescent services in the EPSDT program. This approach could be viewed as a partial carve-out from the larger Medicaid program. Model III does not propose changing existing

arrangements for Medicaid funding of state mental health and mental retardation facilities. Medical/ surgical inpatient psychiatric, outpatient clinic, and pharmacy services would remain with DMAS and the Medicaid Medallion II HMOs. This approach would avoid potentially disastrous interference with or disruption of the very successful Medallion II initiative.

3. Subcontracted administration of these Medicaid services to DMHMRSAS could include provider certification, service authorization (where appropriate, e.g., the MR Waiver), utilization review, data collection and analysis, and, subject to DMAS oversight and approval with respect to compliance with federal law, policy and regulatory development for Medicaid State Plan Option, MR Home and Community-Based Waiver, and any other new or expanded mental health, mental retardation, and substance abuse services related to these SPO and MR Waiver services subsequently added to covered Medicaid services. Some of these functions may be handled by an administrative services only (ASO) organization if DMHMRSAS contracts with one.

4. For example, as part of this expanded and more visible and official Medicaid regulatory and policy role for DMHMRSAS, DMAS would include DMHMRSAS in

   - reviewing and commenting on regulations and policies as DMAS staff draft them;
   - reviewing and participating in the expenditure forecasting models used by DMAS;
   - any evaluations of existing Medallion II contracts;
   - the development of new managed care projects that include or affect any behavioral health care services (e.g., any mental health, mental retardation, or substance abuse services, included in this partial carve out or in other Medicaid programs);
   - and the review of responses to requests for proposals, selection of contractors, and negotiation or renegotiation of managed care contracts under Medallion II or other managed care initiatives.

   This would reduce fragmentation of services and ensure implementation of best practices is maximized for individuals with mental illnesses, mental retardation, and substance dependence and abuse. A council of representatives of consumers, family members, and public and private providers would be established to assist and advise DMHMRSAS and DMAS in the implementation of these regulatory and policy roles and activities.

5. DMAS would continue to handle claims payment. Reimbursement for these partially carved out services would continue to be on a fee-for-service basis. Therefore, the attached graphic depicting this model has been revised to reflect the flow of funds from DMAS to CSBs and private providers, rather than having funds flow to DMHMRSAS and then to CSBs and then to CSB and private providers. Capitation and risk sharing arrangements would not be used to fund these services.

6. The general features of this subcontracted administration, described in the preceding paragraphs 3, 4,and 5, would be included in the applicable DMAS and DMHMRSAS items of the 2000 Appropriation Act.

7. CSBs would function as care coordinators, following specific practice guidelines developed by DMHMRSAS, and as the single-point-of-entry into the services system for Medicaid State Plan Option, MR Waiver, and any other new or expanded mental health, mental retardation, and substance abuse services related to these SPO and waiver services subsequently added to covered Medicaid services. Care coordination is the central service coordination function of CSBs in a managed system of care. In this paper, CSBs include behavioral health authorities. Care coordination would be provided exclusively by CSBs. The HJR 240 Joint Subcommittee recommended that CSBs be local care coordinators and not the primary or only providers of services.[1] Care coordination:

   - assures that consumers receive all of the services and supports identified in the person's individualized services plan (ISP);
   - monitors and evaluates the receipt, effectiveness, and responsiveness of services;
   - takes any necessary actions based on the results of these activities;
   - develops the network of providers from which consumers choose;
   - ensures that each consumer has
     - → his human rights protected and assured;
     - → convenient and timely access to effective appeals and dispute resolution procedures;
     - → maximum practical availability of choice among services and providers; and
     - → the greatest degree of participation and involvement in his evaluation and assessment, development and implementation of his ISP, and admission to and discharge from appropriate care.

   Care coordination is not synonymous with case management. Case management is a clinical service that deals with individual consumers on a regular, face-to-face basis; while care coordination deals with the network of services and its effects on individual consumers. Care coordination is responsible for assuring the preceding outcomes; case management actually works with individual consumers and agencies to achieve them.

   Care coordination includes the following functions and responsibilities.

   - Review and provide feedback to the case manager on the evaluation or assessment of each consumer's service needs.

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[1] *House Document No. 77, Report of the Joint Subcommittee Studying the Future Delivery of Publicly Funded Mental Health, Mental Retardation, and Substance Abuse Services*

- Review and provide feedback to the case manager on the initial ISP and its periodic updates and identify needed changes to the ISP.

- Develop and maintain effective interagency linkages with other agencies and providers within and outside of the traditional services system to facilitate coordinated service planning and service delivery.

- Identify or support and assist the establishment of new service providers and assure that any qualified provider can participate in the publicly funded services system.

- Authorize provision of internal CSB services and procurement of services from external vendors in a manner that promotes the greatest practicable consumer choice by allowing selection from a variety of internal and external providers.

- Identify and resolve barriers to service access and consumer choice.

- Monitor the provision and receipt of services, including the consumer's satisfaction with those services and the extent of choice available to the consumer, through regular reports and periodic contacts with service providers and consumers.

- Review admissions, service enrollments, transfers, and discharges of individuals.

- Perform utilization management functions.

- Evaluate and monitor the effectiveness of services by using standardized, comparable consumer outcome and provider performance measures.

- Conduct follow up contacts with discharged consumers at periodic intervals to longitudinally evaluate the outcomes of services.

- Offer ongoing written feedback to case managers and internal and external service providers about the quality and effectiveness of services and the degree to which expected consumer outcomes have been achieved.

- Document unmet service needs.

Each CSB would describe the structure and process used to implement care coordination responsibilities in its performance contract with DMHMRSAS. If a CSB also delivers some services directly, care coordination must be organizationally distinct and separate from its service delivery functions. In these situations, care coordination must exercise extra diligence to assure that consumers have easy and timely access to an appropriate range of internal and external service providers. If this access does not exist, care coordination must actively support the development of additional public or private providers, which will offer consumers a broader array of choices among providers.

Case management is a direct service that may be delivered by CSBs or other public or private providers. To distinguish care coordination from case management, case management includes the following functions and responsibilities.

- Coordinate service planning and service delivery for each consumer with other agencies and providers within and outside of the traditional services system.
- Link the consumer directly to the services and supports specified in the ISP.
- Assist the individual directly to develop or obtain needed resources (including income supports) and services.
- Enhance community integration through increasing the consumer's community access and involvement.
- Develop and maintain collateral contacts with the consumer's significant others to promote the implementation of the ISP.
- Provide instruction and counseling that guides and supports the consumer in problem-solving and decision-making.

These definitions of care coordination and case management reflect those developed by a work group convened last year by DMHMRSAS in response to recommendation 29 in *House Document 77*. This work group included representatives of consumers, family members CSBs, private providers, local governments, and DMAS.

8. CSBs would also be responsible, through their performance contracts, for network development. Network development includes identifying or supporting and assisting the establishment of new service providers. This would increase and enhance consumer choice and address issues of statewideness and choice. Network development also includes assuring that all qualified private providers can participate in the publicly funded services system and are not excluded from consideration as consumers select providers. The performance contracts that DMHMRSAS negotiates annually with CSBs would require CSBs and any contracted case managers to inform consumers of all qualified providers that are geographically accessible to them, support and facilitate active and unencumbered consumer choice among providers, and document these actions in the consumer's ISP. Although CSBs are the single point of entry and accountability for the publicly funded mental health, mental retardation and substance abuse community services system, the contractual agreement should ensure that consumers' choice of qualified providers is not limited or constrained.

9. The Region III Office of HCFA has expressed concerns about free choice of providers [Section 1902(e)(23) of the Social Security Act and 42CFR 431.51], statewideness [Section 1902(a)(1) of the Act], and comparability of services [Section 1902(a)(10)(B) of the Act] regarding Model III. The actions described in the preceding paragraph on network coordination and in the following paragraph on state fund match for Medicaid federal financial participation (FFP) a

intended to address and alleviate those concerns. Together, these actions would maximize the consumer's choices of providers and make services more available statewide through the expanded participation of private providers.

10. An integral part of successfully implementing Model III is resolving the state fund match for FFP issue, so that CSBs no longer are required to provide match for service expansion and private providers will be able to participate competitively in the provision of these services, as long as they can satisfy the provider qualifications and requirements in Medicaid regulations.

Current Situation

- State general funds are the only source of match to obtain FFP reimbursement. For almost all Medicaid services, this match is appropriated to and paid by DMAS. For SPO and Waiver services, the match has been transferred from the DMHMRSAS appropriation for community services over a period of time as match has been needed to secure FFP and enable payment by DMAS. Once these funds are transferred, they became part of the DMAS base budget for the following year. These state general funds are not local funds; they are appropriated to DMHMRSAS. DMHMRSAS allocates these funds to CSBs to help pay the cost of community mental health, mental retardation, and substance abuse services. Each year, CSBs receive a target for projected revenue from Medicaid based on the previous year's experience. If a CSB bills for more Medicaid SPO or Waiver services than were originally projected, DMHMRSAS deducts the additional state general funds needed for match from future semi-monthly disbursements of state funds to that CSB. No net loss of funds is experienced by the CSB because the reduction in state general funds is offset by increased Medicaid fees. On the other hand, if the CSB bills less than their target, they are allocated the state general fund portion that had been earmarked for match. In this case, the CSB does not collect the full amount of expected Medicaid revenue (FFP plus state general fund match) but at least has the earmarked state general fund match restored.

Situation Under the Proposed Alternative Model III

- All current state funded match for Medicaid SPO and Waiver services that has been transferred from the DMHMRSAS appropriation for community services to DMAS and is appropriated to DMAS as of June 30, 2000 would remain in the DMAS base budget.

- On and after July 1, 2000, all additional match that may be needed for SPO and Waiver services (above the amount already appropriated in the DMAS base budget) would be requested by DMAS during the budget development process and appropriated to DMAS by the General Assembly. There would no longer be any general fund appropriations and transfers from DMHMRSAS to DMAS for SPO and Waiver match or any other new or expanded mental health, mental retardation, and substance abuse services related to these SPO and waiver services subsequently added to the list of covered Medicaid services.

→ This provision would address CSB concerns about continuing to provide additional match for expanded services while resolving the issue of the source of match for private providers. This would support and encourage the expansion of private sector participation in the provision of SPO and Waiver services. It would also treat match for these services in the same manner as match for virtually all other Medicaid services.

→ Currently, state matching funds for FFP is provided by DMHMRSAS from its appropriations for community services. As part of its CSB allocation process each year, DMHMRSAS calculates a Medicaid fee allocation for each CSB, based on the CSB's reimbursement history for covered services. Subsequently, if a CSB does not bill for all of the fees in its allocations (for which state matching funds have been transferred to DMAS), DMHMRSAS, after the end of that fiscal year, has credited the unused match to that CSB's allocation for the following fiscal year. Some CSBs perceive this as "getting their match back." Thus, the potential exists for some CSBs to "lose" a small amount of state general funds if they do not bill for and receive payments from DMAS up to the amounts of their Medicaid fee allocations. The attached Table 1 displays amounts of state funds credited for unused Medicaid match by CSB for FY 1999. As the table indicates, most CSBs needed to provide additional match for services billed above their initial allocations in FY 1999. Thus, these CSBs would not "lose" state funds under this provision.

→ To minimize possible adverse effects, either of under collections or of over collections that DMAS would have to match, that might result from this provision, DMHMRSAS would closely analyze Medicaid fee collection trends during the last half of FY 2000 and make adjustments in each CSB's Medicaid fee allocations and state general fund allocations so that post year-end adjustments for state funded match would be as small as possible.

→ In addition, DMHMRSAS would allow one final set of adjustments for FY 2000 state general funds for Medicaid FFP match after the end of the fiscal year. This would minimize any possible "losses" of state funds for under collecting CSBs and the possible matching fund increases that DMAS would have to seek for CSBs that over collected their Medicaid allocations.

→ While the overwhelming proportion of state matching funds for these services is already in the DMAS budget, the fiscal impact of this provision is difficult to project precisely. The impact should be minimal during the first year for SPO services, since private providers have not participated directly in this option to date. Therefore, there may be relatively little private provider participation, and thus growth, in FY 2001. DMAS and DMHMRSAS should have sufficient information about the mental retardation waiver to be able to predict the need for additional match in the DMAS budget after July 1, 2000, since the waiver is capped at a preset capacity. The only demand for additional state funds for FFP match in the DMAS budget should come from growth caused by providing currently covered services to additional Medicaid enrollees, providing covered SPO services not currently provided by the CSB or

providing new services not previously covered by the Medical Assistance Plan.

11. Maintenance of local government effort refers to the requirement that local governments provide the same amounts of local funds, used to match state general fund allocations provided by the Department, as they provided in the previous fiscal year.

- Section 37.1-199 of the *Code of Virginia* limits state general fund allocations for a CSB to 90 percent of the total of its state and local matching funds. This is the basis for the minimum 10 percent local match requirement. That Code section permits DMHMRSAS to waive this 10 percent match requirement in certain situations pursuant to policy promulgated by the State Mental Health, Mental Retardation and Substance Abuse Services Board. Historically, when CSBs have requested waivers and submitted documentation of efforts to obtain the required match, DMHMRSAS has granted such waivers, rather than reduce state funding and jeopardize the care of consumers.

- As noted earlier, there is no relationship between the state general funds required for Medicaid FFP match and the local government appropriations made to CSBs to meet the local match requirement in section 37.1-199 of the *Code of Virginia*.

- The current Appropriation Act language should be continued and the fiscal year re-dated. Item 347 of the 1999 Appropriation Act reads: "It is the intent of the General Assembly that community mental health, mental retardation and substance abuse services are to be improved throughout the state. Funds provided in this Item shall not be used to supplant the funding effort provided by localities for services existing as of June 30, 1996."

- The following proposed language should be inserted in Item 347 of the FY 2001 Appropriation Act, as well as those of subsequent years with the appropriate item numbers and dates. "Local governments shall not use state general, special, or federal trust funds provided in this item or state general, special, or federal trust funds provided in Item 335 for mental health, mental retardation, or substance abuse services to supplant their funding effort for mental health, mental retardation and substance abuse services existing as of June 30, 2000."

12. Language should be placed in the Appropriation Act concerning the forecasting of Medicaid utilization for the services contained in this partial Medicaid carve-out.

- The following proposed language should be inserted at the appropriate places in the FY 2001 Appropriation Act. "The Department of Medical Assistance Services and Department of Planning and Budget, with the assistance of the Department of Mental Health, Mental Retardation and Substance Abuse Services, shall use their Medicaid expenditure forecast models to project expenditures for SPO, MR Home and Community-Based Waiver, and any other related new or expanded mental health, mental retardation, and substance abuse services related to these SPO and waiver services subsequently added to the list of covered Medicaid services."

13. Language should be included in the current biennium budget that directs DMHMRSAS and DMAS to describe their current operational and policy relationships and their plan for implementing Alternative Model III. The Departments should report to the Chairmen of the House Committee on Appropriations and the Senate Committee on Finance by April 28, 2000.

14. Language should be included in the Appropriation Act that directs DMAS to provide claims and expenditure data to DMHMRSAS about all Medicaid-reimbursed services and information about the recipients of those services. Services include State Plan Option, MR Home and Community-Based Waiver, any new or expanded mental health, mental retardation, and substance abuse services related to these SPO and Waiver services subsequently added to covered Medicaid services, medical/surgical, inpatient psychiatric, outpatient clinic, and any other behavioral health and MR habilitation services. The ASO contracted by the Department could use this information to increase the effectiveness and efficiency of the services system.

C. Summary

1. Alternative Model III would partially address CSB concerns about Medicaid match. It would not restore any of the match transferred to DMAS since 1990. However, it would, from July 1, 2000, eliminate any future transfers for new or expanded services that are contained in this partial carve-out beyond the level offered on June 30, 2000.

2. Alternative Model III would preserve the CSBs' role as the single point of entry into the services system, while eliminating the current perceived CSB monopoly on SPO services and opening up SPO services to direct private sector provision, rather than having the private sector subcontract with CSBs. CSBs could continue to be service providers, too; but private providers would also be able to offer services to consumers directly.

3. Alternative Model III would significantly enhance opportunities for the private sector to offer services in the publicly funded system. This would greatly increase choice for consumers by expanding the number of providers offering service.

4. Alternative Model III is intended to address concerns that have been raised about freedom of choice for consumers and statewide availability of covered Medicaid services.

5. Alternative Model III would introduce enhanced accountability and efficiency in the provision of SPO and Waiver services through the use of an ASO organization contracted by DMHMRSAS.

6. Alternative Model III could be implemented immediately and it does address a major CSB concern: match. Also, the enhanced and formalized policy and regulatory development role of DMHMRSAS addresses another concern of CSBs, consumers, and family members.

Table 1A: FY 1999 State Fund Match Credits

Part A of Table 1 displays amounts of state general funds that were credited to CSBs after the end of FY 1999 when those CSBs billed and received Medicaid payments that totaled less than the amounts of projected Medicaid fees for which DMHMRSAS deducted state general funds for FFP match during FY 1999. These credited funds were then added to the CSBs' FY 2000 allocations of state general funds. Seventy-four percent of the credited funds are for mental retardation services. It is probable that most of these funds reflect match originally deducted from CSB allocations based on the total costs of individualized services plans (ISPs). Subsequently, during the fiscal year, those CSBs may not have billed up to the total amount approved in those ISPs, for instance, due to delayed implementation of individual plans or to changes in the services needed by some consumers. It is possible that a significant proportion of these credited funds could be avoided in the future by carefully review of the actual costs of selected ISPs, where there are wide disparities between the approved ISPs and the actual reimbursements against those plans.

A significant proportion (67%) of the funds for mental health services match credits were credited to only seven of the 28 CSBs with entries in the mental health column. These seven are noted with asterisks (*) in the first column. The third column (%) indicates the percent of the total state match funds that the credit represents. CSBs with percentages above five percent are highlighted with shading. Similarly, an extremely high proportion (81%) of the funds for mental retardation services match credits were also credited to only seven of the 22 CSBs with entries in the mental retardation column. These seven are noted with a dot (•) in the first column. The fifth column (%) indicates the percent of the total state match funds that the credit represents. CSBs with percentages above five percent are highlighted with shading. Again, closer monitoring of reimbursements against plans of care and analysis of trend data comparing aggregate billings against fee allocations at these CSBs could significantly reduce these credits.

Table 1B: FY 1999 State Fund Match Increases

Part B of Table 1 displays increased amounts of state general funds that were needed for match after the end of FY 1999 when those CSBs billed and received Medicaid payments that totaled more than the amounts of projected Medicaid fees for which DMHMRSAS deducted state general funds for FFP match during FY 1999. These increased match funds were subtracted from those CSBs' FY 2000 allocations of state general funds. Seventy-three percent of the increased match funds are for mental retardation services. This situation should be avoided in the future because of the new way in which DMHMRSAS and DMAS are handling the additional funds appropriated during the last General Assembly for additional mental retardation waiver slots. These new funds are being treated as credits against which CSBs can draw for match as needed, rather than being disbursed to CSBs and then subsequently reduced as additional match is needed for new slots.

A significant proportion (60%) of the funds for mental health services match increases occur in only two of the 12 CSBs with entries in the mental health column. These two are noted with asterisks (*) in the first column. The third column (%) indicates the percent of the total state match funds that the increases represent. CSBs with percentages above five percent are highlighted with shading. Similarly, a high proportion (60%) of the funds for mental retardation services match increases occur in only four of the 18 CSBs with entries in the mental retardation column. These four are noted with a dot (•) in the first column. The fifth column (%) indicates the percent of the total state match funds that the increases represent. CSBs with percentages above five percent are highlighted with shading. Again, closer monitoring of reimbursements against plans of care and analysis of trend data comparing aggregate billings against fee allocations at these CSBs might significantly reduce these increases.

Table 1A: FY 1999 State Fund Match Credits	MH	%	MR	%	TOTAL
[illegible]			0	0.00	17,957
Alleghany-Highlands Community Services	5,498	2.22	0	0.00	5,498
[illegible]					272,995
[illegible]					194,728
Central Virginia Community Services	38,322	2.57	0	0.00	38,322
[illegible]	1,184	0.44	[illegible]		135,854
Chesterfield CSB	14,497	3.14	36,487	2.50	50,984
Colonial MH&MR Services	11,853	3.91	0	0.00	11,853
Crossroads Community Services	0	0.00	2,754	0.31	2,754
Cumberland Mountain Community Services	6,358	1.07	4,480	1.04	10,838
Danville-Pittsylvania Community Services	0	0.00	16,525	3.55	16,525
Dickenson County Community Services	0	0.00	2,016	2.00	2,016
District 19 CSB	17,229	1.66	0	0.00	17,229
[illegible]	8,094	3.39	[illegible]		90,060
[illegible]	27,905	3.91	[illegible]		866,025
Goochland-Powhatan Community Services	1,003	0.70	0	0.00	1,003
[illegible]	[illegible]		[illegible]		200,339
[illegible]	[illegible]		[illegible]		25,530
[illegible]	22,194	4.85	[illegible]		89,236
[illegible]	[illegible]		[illegible]		228,940
Highlands Community Services	0	0.00	3,757	1.96	3,757
[illegible]	[illegible]		0	0.00	19,976
Middle Peninsula-Northern Neck CSB	0	0.00	0	0.00	0
Mt. Rogers Community MH&MR Service Board	7,002	1.13	15,248	3.18	22,250
New River Valley Community Services	0	0.00	0	0.00	0
[illegible]	[illegible]		0	0.00	84,299
Northwestern Community Services	0	0.00	0	0.00	0
Piedmont Community Services	0	0.00	0	0.00	0
[illegible]	0	0.00	[illegible]		27,686
Portsmouth Dept. of Behavioral Healthcare Srvcs	4,884	1.67	0	0.00	4,884
[illegible]	0	0.00	[illegible]		305,084
[illegible]	[illegible]		0	0.00	71,189
[illegible]	19,881	3.98	[illegible]		61,717
Region Ten CSB	0	0.00	0	0.00	0
Richmond Behavioral Health Authority	5,433	0.21	25,844	3.03	31,277
[illegible]	13,097	4.52	[illegible]		71,813
Southside CSB	0	0.00	0	0.00	0
Valley CSB	16,684	3.19	0	0.00	16,684
[illegible]	[illegible]		[illegible]		[illegible]
[illegible]	[illegible]		0	0.00	40,392
Statewide Average	942,687		2,653,882		3,596,569

Table 1B: FY 1999 State Fund Match Increases	MH	%	MR	%	TOTAL
[illegible]	0	0.00	[illegible]	[illegible]	57,390
[illegible]	0	0.00	[illegible]	[illegible]	12,823
Arlington County CSB	0	0.00	0	0.00	0
Blue Ridge Community Services	0	0.00	0	0.00	0
[illegible]	0	0.00	[illegible]	[illegible]	248,176
Chesapeake CSB	0	0.00	0	0.00	0
Chesterfield CSB	0	0.00	0	0.00	0
[illegible]	0	0.00	[illegible]	[illegible]	77,909
Crossroads Community Services	14,350	2.53	0	0.00	14,350
Cumberland Mountain Community Services	0	0.00	0	0.00	0
Danville-Pittsylvania Community Services	4,239	1.09	0	0.00	4,239
[illegible]	[illegible]	[illegible]	0	0.00	11,094
[illegible]	0	0.00	[illegible]	[illegible]	29,002
Eastern Shore CSB	0	0.00	0	0.00	0
Fairfax-Falls Church CSB	0	0.00	0	0.00	0
[illegible]	0	0.00	[illegible]	[illegible]	8,866
Hampton-Newport News CSB	0	0.00	0	0.00	0
Hanover County CSB	0	0.00	0	0.00	0
Harrisonburg-Rockingham CSB	0	0.00	0	0.00	0
[illegible]enrico Area MH&R Services Board	0	0.00	0	0.00	0
[illegible]	[illegible]	[illegible]	0	0.00	25,937
Loudoun County CSB	0	0.00	23,441	4.55	23,441
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	389,024
Mt. Rogers Community MH&MR Service Board	0	0.00	0	0.00	0
[illegible]	11,307	1.79	[illegible]	[illegible]	70,689
Norfolk CSB	0	0.00	8,777	0.83	8,777
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	136,053
[illegible]	17,408	2.71	[illegible]	[illegible]	151,898
[illegible]	[illegible]	[illegible]	0	0.00	33,247
[illegible]	0	0.00	[illegible]	[illegible]	38,085
[illegible]	[illegible]	[illegible]	0	0.00	28,730
Rappahannock Area CSB	0	0.00	26,431	3.04	26,431
Rappahannock-Rapidan CSB	0	0.00	0	0.00	0
Region Ten CSB	5,278	0.43	40,613	4.28	45,891
Richmond Behavioral Health Authority	0	0.00	0	0.00	0
Rockbridge Area CSB	0	0.00	0	0.00	0
Southside CSB	12,639	2.44	25,493	3.55	38,132
Valley CSB	0	0.00	10,135	3.17	10,135
[illegible]irginia Beach CSB	0	0.00	0	0.00	0
[illegible]	0	0.00	[illegible]	[illegible]	58,137
Statewide Average	413,361		1,135,095		1,548,456

Table 2: SFY 1999 CSB Local Match Ratios Source: SFY 1999 4th Quarter Reports	**Total State Funds**	**Total Local Match**	**State/Local Match Ratio**
Fairfax-Falls Church CSB	9,519,850	50,051,599	15.98/84.02
Loudoun County CSB	1,486,639	5,028,058	22.82/77.18
Alexandria CSB	3,126,223	7,405,824	29.68/70.32
Arlington County CSB	3,770,895	8,385,204	31.02/68.98
Henrico Area MH&R Services Board	3,721,444	7,764,847	32.40/67.60
Prince William County CSB	3,392,302	5,760,487	37.06/62.94
Hanover County CSB	1,307,788	2,184,339	37.45/62.55
Chesterfield CSB	2,601,916	4,113,374	38.75/61.25
Virginia Beach CSB	4,915,585	5,277,293	48.23/51.77
Chesapeake CSB	3,776,021	2,934,544	56.27/43.73
Rappahannock Area CSB	1,896,748	700,404	73.03/26.97
Region Ten CSB	2,393,858	750,377	76.13/23.87
Colonial MH&MR Services Board	3,112,366	961,136	76.41/23.59
Hampton-Newport News CSB	8,125,278	2,240,428	78.39/21.61
Richmond Behavioral Health Authority	6,963,942	1,915,391	78.43/21.57
Norfolk CSB	5,931,138	1,576,392	79.00/21.00
Central Virginia Community Services	2,823,511	695,303	80.24/19.76
Northwestern Community Services	3,095,841	649,042	82.67/17.33
Rockbridge Area CSB	1,109,299	227,689	82.97/17.03
Goochland-Powhatan Community Services	1,274,653	250,630	83.57/16.43
Crossroads Community Services	1,513,609	282,255	84.28/15.72
Western Tidewater CSB	2,613,580	452,458	85.24/14.76
Highlands Community Services	2,273,013	367,371	86.09/13.91
Mt. Rogers Community MH&MR Services Board	2,807,074	411,573	87.21/12.79
Blue Ridge Community Services	5,506,028	760,812	87.86/12.14
District 19 CSB	4,252,075	583,862	87.93/12.07
Danville-Pittsylvania Community Services	2,410,143	310,695	88.58/11.42
Alleghany Highlands Community Services	822,810	105,553	88.63/11.37
Middle Peninsula-Northern Neck CSB	2,381,209	298,879	88.85/11.15
Harrisonburg-Rockingham CSB	1,962,737	244,805	88.91/11.09
Planning District 1 CSB	2,122,825	261,777	89.02/10.98
Eastern Shore CSB	1,607,896	189,991	89.43/10.57
Piedmont Community Services	2,278,653	255,940	89.90/10.10
New River Valley Community Services	2,692,447	296,985	90.07/9.93
Southside CSB	2,078,176	215,285	90.61/9.39
Dickenson County Community Services	727,728	74,920	90.67/9.33
Rappahannock-Rapidan CSB	2,916,965	277,027	91.34/8.67
Portsmouth Dept. of Behavioral Healthcare Services	4,255,340	398,396	91.44/8.56
Valley CSB	3,548,144	251,249	93.39/6.61
Cumberland Mountain Community Services	2,223,293	152,502	93.58/6.42
Statewide Total	125,339,042	115,064,696	52.14/47.86

Table 3: State/Local Match Ratios	FY 1999	FY 1998	FY 1997
Alexandria CSB	29.68/70.32	30.86/69.14	33.26/66.74
Alleghany-Highlands Community Services	88.63/11.37	86.40/13.60	85.85/14.15
Arlington County CSB	31.02/68.98	34.26/65.74	30.32/69.68
Blue Ridge Community Services	87.86/12.14	84.78/15.22	84.08/15.92
Central Virginia Community Services	80.24/19.76	82.34/17.66	83.67/16.33
Chesapeake CSB	56.27/43.73	55.99/44.01	57.20/42.80
Chesterfield CSB	38.75/61.25	36.39/63.61	38.73/61.27
Colonial MH&MR Services	76.41/23.59	75.03/24.97	75.60/24.40
Crossroads Community Services	84.28/15.72	82.39/17.61	84.13/15.87
Cumberland Mountain Community Services			
Danville-Pittsylvania Community Services	88.58/11.42	88.72/11.28	88.92/11.08
Dickenson County Community Services		88.79/11.21	88.74/11.26
District 19 CSB	87.93/12.07	88.87/11.13	87.58/12.42
Eastern Shore CSB	89.43/10.57	89.95/10.05	
Fairfax-Falls Church CSB	15.98/84.02	14.88/85.12	16.95/83.05
Goochland-Powhatan Community Services	83.57/16.43	83.21/16.79	82.87/17.13
Hampton-Newport News CSB	78.39/21.61	75.47/24.53	75.52/24.48
Hanover County CSB	37.45/62.55	42.80/57.20	48.50/51.50
Harrisonburg-Rockingham CSB	88.91/11.09	89.15/10.85	
Henrico Area MH&R Services Board	32.40/67.60	31.67/68.33	33.33/66.67
Highlands Community Services	86.09/13.91	82.78/17.22	81.88/18.12
Loudoun County CSB	22.82/77.18	22.25/77.75	22.54/77.46
Middle Peninsula-Northern Neck CSB	88.85/11.15	86.13/13.87	84.22/15.78
Mt. Rogers Community MH&MR Service Board	87.21/12.79	87.88/12.12	
New River Valley Community Services		88.92/11.08	89.46/10.54
Norfolk CSB	79.00/21.00	78.27/21.73	78.70/21.30
Northwestern Community Services	82.67/17.33	83.44/16.56	83.54/16.46
Piedmont Community Services	89.90/10.10	89.92/10.08	89.19/10.81
Planning District 1 CSB	89.02/10.98	86.55/13.45	88.21/11.79
Portsmouth Dept. of Behavioral Healthcare Services		89.78/10.22	88.24/11.76
Prince William County CSB	37.06/62.94	30.70/69.30	30.21/69.79
Rappahannock Area CSB	73.03/26.97	72.97/27.03	79.89/20.11
Rappahannock-Rapidan CSB		88.42/11.58	87.19/12.81
Region Ten CSB	76.13/23.87	76.10/23.90	78.62/21.38
Richmond Behavioral Health Authority	78.43/21.57	76.81/23.19	73.49/26.51
Rockbridge Area CSB	82.97/17.03	83.21/16.79	85.35/14.65
Southside CSB		89.52/10.48	89.61/10.39
Valley CSB		89.29/10.71	
Virginia Beach CSB	48.23/51.77	43.15/56.85	40.70/59.30
Western Tidewater CSB	85.24/14.76	87.77/12.23	88.15/11.85
Statewide Average	52.14/47.86	50.44/49.56	51.76/48.24

Table 4: Local Tax Matching Funds	FY 1999	FY 1998	FY 1997
Alexandria CSB	7,428,087	7,021,169	6,363,898
Alleghany-Highlands Community Services	88,286	[illegible]	[illegible]
Arlington County CSB	8,012,945	[illegible]	[illegible]
Blue Ridge Community Services	586,998	574,567	564,079
Central Virginia Community Services	695,341	668,491	648,968
Chesapeake CSB	2,699,764	2,662,162	2,596,106
Chesterfield CSB	4,057,400	3,946,400	3,822,300
Colonial MH&MR Services	1,048,454	1,009,086	945,536
Crossroads Community Services	281,596	263,684	248,131
Cumberland Mountain Community Services [2]	152,007	152,007	152,007
Danville-Pittsylvania Community Services	260,316	255,702	251,409
Dickenson County Community Services	69,660	63,370	63,370
District 19 CSB	475,702	459,458	425,039
Eastern Shore CSB [2]	167,267	167,267	167,267
Fairfax-Falls Church CSB	50,027,732	45,993,478	43,251,342
Goochland-Powhatan Community Services	250,630	229,934	218,984
Hampton-Newport News CSB	2,240,428	2,206,289	2,152,098
Hanover County CSB	1,840,501	1,358,216	1,217,867
Harrisonburg-Rockingham CSB	244,805	237,675	228,501
Henrico Area MH&R Services Board	7,764,847	7,511,045	6,854,530
Highlands Community Services	306,978	292,359	278,437
Loudoun County CSB	5,271,412	4,726,441	4,017,3
Middle Peninsula-Northern Neck CSB	299,748	[illegible]	[illegible]
Mt. Rogers Community MH&MR Service Board	322,687	306,497	277,295
New River Valley Community Services	261,060	258,520	257,996
Norfolk CSB	[illegible]	[illegible]	[illegible]
Northwestern Community Services	519,723	477,770	425,323
Piedmont Community Services	248,633	213,618	213,618
Planning District 1 CSB [2]	261,777	261,777	261,777
Portsmouth Dept. of Behavioral Healthcare Services	[illegible]	[illegible]	483,056
Prince William County CSB	[illegible]	[illegible]	[illegible]
Rappahannock Area CSB	694,419	517,908	481,357
Rappahannock-Rapidan CSB	[illegible]	[illegible]	325,600
Region Ten CSB	750,377	669,820	644,333
Richmond Behavioral Health Authority	[illegible]	[illegible]	[illegible]
Rockbridge Area CSB	165,037	157,209	152,625
Southside CSB [2]	213,244	213,244	213,244
Valley CSB	245,368	243,249	227,876
Virginia Beach CSB	5,807,736	5,414,968	4,543,771
Western Tidewater CSB	357,400	327,490	308,67[illegible]
Statewide Totals	113,163,465	107,237,649	102,961,9

APPENDIX VI-6

REENROLLED

CHAPTER 969 **Appendix VI-6**

An Act to amend and reenact §§ 2.1-1.1, 2.1-1.3, 2.1-1.5, 2.1-51.15, 2.1-116, 2.1-122, 2.1-373.13, 2.1-703.1, 2.1-762, 9-271, 9-323, 37.1-1, 37.1-84.1, 51.5-1, 51.5-2, 51.5-40, 51.5-46, 63.1-182.1 and 63.1-314.8 of the Code of Virginia; to amend the Code of Virginia by adding sections numbered 37.1-84.3, 37.1-182.3 and 37.1-185.1 and by adding in Title 51.5 a chapter numbered 8.1, consisting of sections numbered 51.5-39.1 through 51.5-39.11; and to repeal Chapter 8 (§§ 51.5-36 through 51.5-39) of Title 51.5 of the Code of Virginia, relating to persons with mental retardation, developmental disabilities, or mental illness; civil penalties.

[S 1224]

Approved April 7, 1999

Be it enacted by the General Assembly of Virginia:

1. That §§ 37.1-1 and 37.1-84.1 are amended and reenacted and that the Code of Virginia is amended by adding sections numbered 37.1-84.3, 37.1-182.3 and 37.1-185.1 as follows:

§ 37.1-1. Definitions.

As used in this title except where the context requires a different meaning or where it is otherwise provided, the following words shall have the meaning ascribed to them:

"Abuse" means any act or failure to act by an employee or other person responsible for the care of an individual in a facility or program operated, licensed, or funded by the Department, excluding those operated by the Department of Corrections, that was performed or was failed to be performed knowingly, recklessly, or intentionally, and that caused or might have caused physical or psychological harm, injury, or death to a person receiving care or treatment for mental illness, mental retardation or substance abuse. Examples of abuse include, but are not limited to, acts such as:

1. Rape, sexual assault, or other criminal sexual behavior;

2. Assault or battery;

3. Use of language that demeans, threatens, intimidates or humiliates the person;

4. Misuse or misappropriation of the person's assets, goods, or property;

5. Use of excessive force when placing a person in physical or mechanical restraint;

6. Use of physical or mechanical restraints on a person that is not in compliance with federal and state laws, regulations, and policies, professionally accepted standards of practice or the person's individualized services plan; and

7. Use of more restrictive or intensive services or denial of services to punish the person or that is not consistent with his individualized services plan;

"Alcoholic" means a person who: (i) through use of alcohol has become dangerous to the public or himself; or (ii) because of such alcohol use is medically determined to be in need of medical or psychiatric care, treatment, rehabilitation or counseling;

"Board" means the State Mental Health, Mental Retardation and Substance Abuse Services Board;

"Client," as used in Chapter 10 (§ 37.1-194 et seq.) of this title, means any person receiving a service provided by personnel or facilities under the jurisdiction or supervision of a community services board;

"Commissioner" means the Commissioner of Mental Health, Mental Retardation and Substance Abuse Services;

"Community services board" means a citizens' board established pursuant to § 37.1-195 which provides mental health, mental retardation and substance abuse programs and services within the political subdivision or political subdivisions participating on the board;

"Consumer" means a current or former direct recipient of public or private mental health, mental retardation, or substance abuse treatment or habilitation services;

"Department" means the Department of Mental Health, Mental Retardation and Substance Abuse Services;

"Director" means the chief executive officer of a hospital or of a training center for the mentally retarded;

"Drug addict" means a person who: (i) through use of habit-forming drugs or other drugs enumerated in the Virginia Drug Control Act (§ 54.1-3400 et seq.) as controlled drugs, has become dangerous to the public or himself; or (ii) because of such drug use, is medically determined to be in need of medical or psychiatric care, treatment, rehabilitation or counseling;

"Facility" means a state or private hospital, training center for the mentally retarded, psychiatric hospital, or other type of residential and ambulatory mental health or mental retardation facility and when modified by the word "state" it means a facility under the supervision and management of the Commissioner;

"Family member" means an immediate family member of a consumer or the principal caregiver of a consumer. A principal caregiver is a person who acts in the place of an immediate family member, including other relatives and foster care providers, but does not have a proprietary interest in the care of the consumer;

"Hospital" or "hospitals" when not modified by the words "state" or "private" shall be deemed to include both state hospitals and private hospitals devoted to or with facilities for the care and treatment of the mentally ill or mentally retarded;

"Judge" includes only the judges, associate judges and substitute judges of general district courts within the meaning of Chapter 4.1 (§ 16.1-69.1 et seq.) of Title 16.1 and of juvenile and domestic relations district courts within the meaning of Chapter 11 (§ 16.1-226 et seq.) of Title 16.1, as well as the special justices authorized by § 37.1-88;

"Legal resident" means any person who is a bona fide resident of the Commonwealth of Virginia;

"Mental retardation" means substantial subaverage general intellectual functioning which originates during the development period and is associated with impairment in adaptive behavior;

"Mentally ill" means any person afflicted with mental disease to such an extent that for his own welfare or the welfare of others, he requires care and treatment; provided, that for the purposes of Chapter 2 (§ 37.1-63 et seq.) of this title, the term "mentally ill" shall be deemed to include any person who is a drug addict or alcoholic;

"Neglect" means failure by an individual, program or facility responsible for providing services to provide nourishment, treatment, care, goods, or services necessary to the health, safety or welfare of a person receiving care or treatment for mental illness, mental retardation or substance abuse;

"Patient" or "resident" means a person voluntarily or involuntarily admitted to or residing in a facility according to the provisions of this title;

"Private hospital" means a hospital or institution which is duly licensed pursuant to the provisions of this title;

"Private institution" means an establishment which is not operated by the Department and which is licensed under Chapter 8 (§ 37.1-179 et seq.) of this title for the care or treatment of mentally ill or mentally retarded persons, including psychiatric wards of general hospitals;

"Property" as used in §§ 37.1-12 and 37.1-13 includes land and structures thereon;

"State hospital" means a hospital, training school or other such institution operated by the Department for the care and treatment of the mentally ill or mentally retarded;

"System of facilities" or "facility system" means the entire system of hospitals and training centers for the mentally retarded and other types of facilities for the residential and ambulatory treatment, training and rehabilitation of the mentally ill and mentally retarded as defined in this section under the general supervision and management of the Commissioner;

"Training center for the mentally retarded" means a regional facility for the treatment, training and habilitation of the mentally retarded in a specific geographical area.

§ 37.1-84.1. Rights of patients and residents.

A. Each person who is a patient ~~or~~ , resident, *or consumer* in a hospital ~~or~~, other facility, *or program* operated, funded, or licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services, *excluding those operated by the Department of Corrections,* shall be assured his legal rights and care consistent with basic human dignity insofar as it is within the reasonable capabilities and limitations of the Department, *funded program,* or licensee and is consistent with sound therapeutic treatment. Each person admitted to a hospital ~~or~~, other facility, *or program* operated, funded, or licensed by the Department shall:

1. Retain his legal rights as provided by state and federal law;

2. Receive prompt evaluation and treatment or training about which he is informed insofar as he is capable of understanding;

3. Be treated with dignity as a human being and be free from abuse *or neglect*;

4. Not be the subject of experimental or investigational research without his prior written and informed consent or that of his legally authorized representative. *No employee of the Department or a community services board, behavioral health authority, or local government department with a policy-advisory community services board; a community services board, behavioral health authority, or local government with a policy-advisory community services board contractor; or any other public or private program or facility licensed or funded by the Department shall serve as a legally authorized representative for a consumer being treated in any Department, community services board, behavioral health authority, local government department with a policy-advisory community services board or other licensed or funded public or private program or facility, unless the employee is a relative or legal guardian of the consumer*;

5. Be afforded an opportunity to have access to consultation with a private physician at his own expense and, in the case of hazardous treatment or irreversible surgical procedures, have, upon request, an impartial review prior to implementation, except in case of emergency procedures required for the preservation of his health;

6. Be treated under the least restrictive conditions consistent with his condition and not be subjected to unnecessary physical restraint and isolation;

7. Be allowed to send and receive sealed letter mail;

8. Have access to his medical and mental records and be assured of their confidentiality but, notwithstanding other provisions of law, such right shall be limited to access consistent with his condition and sound therapeutic treatment; ~~and~~

9. Have the right to an impartial review of violations of the rights assured under this section and the right of access to legal counsel*; and*

10. Be afforded appropriate opportunities, consistent with the person's capabilities and capacity, to participate in the development and implementation of his individualized services plan.

The State Mental Health, Mental Retardation and Substance Abuse Services Board shall promulgate regulations relative to the implementation of the above after due notice and public hearing as provided for in the Administrative Process Act (§ 9-6.14:1 et seq.).

The Board shall also promulgate regulations delineating the rights of patients ~~and~~, residents, *and consumers* with respect to nutritionally adequate diet, safe and sanitary housing, participation in nontherapeutic labor, attendance or nonattendance at religious services, participation in treatment decision-making, including due process procedures to be followed when a patient ~~or~~, resident, *or consumer* may be unable to make an informed decision, use of telephones, suitable clothing, and possession of money and valuables and related matters. *Licensure pursuant to Chapter 8 (§ 37.1-179 et seq.) of this title shall be contingent upon substantial compliance with human rights regulations as determined by periodic human rights reviews performed by the Department. Human rights reviews will be conducted as part of the Department's licensure reviews or, at the Department's discretion, whenever human rights issues arise.* Such latter regulations shall be applicable to all hospitals ~~and~~, other facilities, *and programs* operated, funded, or licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services but such hospitals ~~or~~, facilities, *or programs* may be classified as to patient ~~or~~, resident, *or consumer* population, size, type of services, or other reasonable classification.

B. The Board shall promulgate regulations requiring public and private facilities and programs licensed or funded by the Department to provide nonprivileged information and statistical data to the Department related to (i) the results of investigations of abuse or neglect, (ii) deaths and serious injuries, (iii) instances of seclusion and restraint, including the duration, type and rationale for use per consumer, and (iv) findings by state or local human rights committees or the Office of Human Rights within the Department of human rights violations, abuse or neglect. The Board's regulations shall address the procedures collecting, compiling, encrypting and releasing the data. Such information and statistical data shall be made available to the public in a format from which all provider, patient, resident and consumer-identifying information has been removed. The Board's regulations shall specifically exclude all proceedings, minutes, records, and reports of any committee

or nonprofit entity providing a centralized credentialing service which are identified as privileged pursuant to § 8.01-581.17.

§ 37.1-84.3. Appointments to state and local human rights committees.

The Board shall appoint a state human rights committee, which shall appoint local human rights committees to address alleged violations of consumers' human rights. One-third of the appointments made to the state or local human rights committees shall be consumers or family members of consumers, with at least two consumers who are receiving services on each committee. Remaining appointments shall include lawyers, health care providers, and persons with interest or knowledge or training in the mental health, mental retardation or substance abuse field. No current employee of the Department or a community services board, behavioral health authority, or local government department with a policy-advisory community services board shall serve as a member of the state human rights committee. No current employee of the Department; a community services board, behavioral health authority or local government department with a policy-advisory community services board; or any facility or program licensed or funded by the Department shall serve as a member of any local human rights committee that serves an oversight function for the employing facility, program or organization.

§ 37.1-182.3. Human rights review.

Licensure pursuant to this chapter shall be contingent upon substantial compliance with § 37.1-84.1 and acceptable implementation of the human rights regulations promulgated pursuant thereto as determined by periodic human rights reviews performed by the Department. Such reviews shall be conducted as part of the Department's licensure reviews or, at the agency's discretion, whenever human rights issues arise.

§ 37.1-185.1. Human rights enforcement and sanctions.

A. Notwithstanding any other provision of law, following a proceeding as provided in § 9-6.14:11, the Commissioner may issue a special order for a violation of any of the provisions of § 37.1-84.1 or any rule or regulation promulgated under any provision of § 37.1-84.1 or of this chapter that adversely impacts the human rights of consumers or poses an imminent and substantial threat to the health, safety or welfare of consumers. The issuance of a special order shall be considered a case decision as defined in § 9-6.14:4. The Commissioner shall not delegate his authority to impose civil penalties in conjunction with the issuance of special orders. The Commissioner may take the following actions to sanction public and private hospitals, facilities or programs licensed or funded by the Department for noncompliance with § 37.1-84.1, the human rights regulations or this chapter:

1. Place any such hospital, facility or program on probation upon finding that it is substantially out of compliance with the human rights regulations and that the health or safety of consumers is at risk.

2. Reduce licensed capacity or prohibit new admissions when the Commissioner concludes that the hospital, facility or program cannot make necessary corrections to achieve compliance with regulations except by a temporary restriction of its scope of service.

3. Require that probationary status announcements, provisional licenses, and denial or revocation notices be of sufficient size and distinction and be posted in a prominent place at each public entrance of the hospital, facility or program.

4. Mandate training for hospital, facility or program employees, with any costs to be borne by the hospital, facility or program, when the Commissioner concludes that the lack of such training has led directly to violations of regulations.

5. Assess civil penalties of not more than $500 per violation per day upon finding that the licensed or funded hospital, facility or program is substantially out of compliance with the human rights regulations and that the health or safety of consumers is at risk.

6. Withhold funds from licensees or programs receiving public funds that are in violation of the human rights regulations.

7. Inform other public agencies that provide funds to the licensee or the program, such as the Department of Social Services and the Department of Medical Assistance Services, of any licensee or program that is in violation of the human rights regulations.

B. "Special order" means an administrative order issued to any party licensed or funded by the Department pursuant to this chapter that has a stated duration of not more than twelve months and

that may include a civil penalty that shall not exceed $500 per violation per day, prohibition of new admissions or reduction of licensed capacity for violations of § 37.1-84.1, the human rights regulations or this chapter.

C. The Board shall promulgate regulations to implement the provisions of this section.

2. That §§ 2.1-1.1, 2.1-1.3, 2.1-1.5, 2.1-51.15, 2.1-116, 2.1-122, 2.1-373.13, 2.1-703.1, 2.1-762, 9-271, 9-323, 51.5-1, 51.5-2, 51.5-40, 51.5-46, 63.1-182.1 and 63.1-314.8 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding in Title 51.5 a chapter numbered 8.1, consisting of sections numbered 51.5-39.1 through 51.5-39.11, as follows:

§ 2.1-1.1. Departments generally.

There shall be, in addition to such others as may be established by law, the following administrative departments of the state government:

Chesapeake Bay Local Assistance Department.
Department for the Aging.
Department for the Deaf and Hard-of-Hearing.
~~Department for Rights of Virginians With Disabilities.~~
Department for the Visually Handicapped.
Department of Accounts.
Department of Agriculture and Consumer Services.
Department of Alcoholic Beverage Control.
Department of Aviation.
Department of Business Assistance.
Department of Conservation and Recreation.
Department of Corporations.
Department of Correctional Education.
Department of Corrections.
Department of Criminal Justice Services.
Department of Education.
Department of Emergency Services.
Department of Employee Relations Counselors.
Department of Environmental Quality.
Department of Fire Programs.
Department of Forestry.
Department of Game and Inland Fisheries.
Department of General Services.
Department of Health.
Department of Health Professions.
Department of Historic Resources.
Department of Housing and Community Development.
Department of Information Technology.
Department of Juvenile Justice.
Department of Labor and Industry.
Department of Law.
Department of Medical Assistance Services.
Department of Mental Health, Mental Retardation and Substance Abuse Services.
Department of Military Affairs.
Department of Mines, Minerals and Energy.
Department of Minority Business Enterprise.
Department of Motor Vehicles.
Department of Personnel and Training.
Department of Planning and Budget.
Department of Professional and Occupational Regulation.
Department of Rail and Public Transportation.
Department of Rehabilitative Services.
Department of Social Services.

Department of State Police.
Department of Taxation.
Department of Transportation.
Department of the Treasury.
Department of Veterans' Affairs.
Governor's Employment and Training Department.

§ 2.1-1.3. Entities subject to standard nomenclature.

The following independent administrative entities are subject to the standard nomenclature provisions of § 2.1-1.2:

Chesapeake Bay Local Assistance Department.
Department for the Aging.
Department for the Deaf and Hard-of-Hearing.
~~Department for Rights of Virginians With Disabilities.~~
Department for the Visually Handicapped.
Department of Accounts.
Department of Agriculture and Consumer Services.
Department of Alcoholic Beverage Control.
Department of Aviation.
Department of Business Assistance.
Department of Conservation and Recreation.
Department of Correctional Education.
Department of Corrections.
Department of Criminal Justice Services.
Department of Education.
Department of Emergency Services.
Department of Environmental Quality.
Department of Employee Relations Counselors.
Department of Fire Programs.
Department of Forestry.
Department of Game and Inland Fisheries.
Department of General Services.
Department of Health.
Department of Health Professions.
Department of Historic Resources.
Department of Housing and Community Development.
Department of Information Technology.
Department of Juvenile Justice.
Department of Labor and Industry.
Department of Medical Assistance Services.
Department of Mental Health, Mental Retardation and Substance Abuse Services.
Department of Military Affairs.
Department of Mines, Minerals and Energy.
Department of Minority Business Enterprise.
Department of Motor Vehicles.
Department of Personnel and Training.
Department of Planning and Budget.
Department of Professional and Occupational Regulation.
Department of Rail and Public Transportation.
Department of Rehabilitative Services.
Department of Social Services.
Department of State Police.
Department of Taxation.
Department of Transportation.
Department of the Treasury.

Department of Veterans' Affairs.
Governor's Employment and Training Department.
§ 2.1-1.5. Entities not subject to standard nomenclature.
The following entities are not subject to the provisions of § 2.1-1.2 due to the unique characteristics or the enabling legislation of the entities:

Authorities

Assistive Technology Loan Fund Authority.
Medical College of Virginia Hospitals Authority.
Richmond Eye and Ear Hospital Authority.
Small Business Financing Authority.
Virginia Agriculture Development Authority.
Virginia College Building Authority.
Virginia Economic Development Partnership.
Virginia Housing Development Authority.
Virginia Information Providers Network Authority.
Virginia Innovative Technology Authority.
Virginia Port Authority.
Virginia Public Building Authority.
Virginia Public School Authority.
Virginia Resources Authority.

Boards

Board for Protection and Advocacy.
Board of Commissioners, Virginia Agriculture Development Authority.
Board of Commissioners, Virginia Port Authority.
Board of Directors, Assistive Technology Loan Fund Authority.
Board of Directors, Medical College of Virginia Hospitals Authority.
Board of Directors, Richmond Eye and Ear Hospital Authority.
Board of Directors, Small Business Financing Authority.
Board of Directors, Virginia Economic Development Partnership.
Board of Directors, Virginia Innovative Technology Authority.
Board of Directors, Virginia Resources Authority.
Board of Regents, Gunston Hall Plantation.
Board of Regents, James Monroe Memorial Law Office and Library.
Board of Trustees, Family and Children's Trust Fund.
Board of Trustees, Frontier Culture Museum of Virginia.
Board of Trustees, Jamestown-Yorktown Foundation.
Board of Trustees, Miller School of Albemarle.
Board of Trustees, Rural Virginia Development Foundation.
Board of Trustees, The Science Museum of Virginia.
Board of Trustees, Virginia Museum of Fine Arts.
Board of Trustees, Virginia Museum of Natural History.
Board of Trustees, Virginia Outdoor Foundation.
Board of Visitors, Christopher Newport University.
Board of Visitors, George Mason University.
Board of Visitors, Gunston Hall Plantation.
Board of Visitors, James Madison University.
Board of Visitors, Longwood College.
Board of Visitors, Mary Washington College.
Board of Visitors, Norfolk State University.
Board of Visitors, Old Dominion University.
Board of Visitors, Radford University.
Board of Visitors, The College of William and Mary in Virginia.
Board of Visitors to Mount Vernon.
Board of Visitors, University of Virginia.

Board of Visitors, Virginia Commonwealth University.
Board of Visitors, Virginia Military Institute.
Board of Visitors, Virginia Polytechnic Institute and State University.
Board of Visitors, Virginia State University.
Commonwealth Health Research Board.
Governing Board, Virginia College Building Authority.
Governing Board, Virginia Public School Authority.
Library Board, The Library of Virginia.
Motor Vehicle Dealer Board.
State Board for Community Colleges, Virginia Community College System.
Virginia-Israel Advisory Board.
(Effective until July 1, 2002) Wireless E-911 Service Board.

Commissions

Advisory Commission on the Virginia Schools for the Deaf and the Blind.
Alexandria Historical Restoration and Preservation Commission.
Charitable Gaming Commission.
Chesapeake Bay Bridge and Tunnel Commission.
Hampton Roads Sanitation District Commission.

Districts

Chesapeake Bay Bridge and Tunnel District.
Hampton Roads Sanitation District.

Educational Institutions

Christopher Newport University.
Frontier Culture Museum of Virginia.
George Mason University.
James Madison University.
Jamestown-Yorktown Foundation.
Longwood College.
Mary Washington College.
Miller School of Albemarle.
Norfolk State University.
Old Dominion University.
Radford University.
The College of William and Mary in Virginia.
The Library of Virginia.
The Science Museum of Virginia.
University of Virginia.
Virginia Commonwealth University.
Virginia Community College System.
Virginia Military Institute.
Virginia Museum of Fine Arts.
Virginia Polytechnic Institute and State University.
Virginia State University.

Foundations

Chippokes Plantation Farm Foundation.
Rural Virginia Development Foundation.
Virginia Arts Foundation.
Virginia Conservation and Recreation Foundation.
Virginia Historic Preservation Foundation.
Virginia Outdoor Foundation.

Museum

Virginia Museum of Natural History.

Office

Virginia Office for Protection and Advocacy.

Partnership
A. L. Philpott Manufacturing Extension Partnership.
Plantation
Gunston Hall Plantation.

§ 2.1-51.15. Agencies for which responsible.

The Secretary of Health and Human Resources shall be responsible to the Governor for the following agencies: Department of Health, Department for the Visually Handicapped, Department of Health Professions, Department for the Aging, Department of Mental Health, Mental Retardation and Substance Abuse Services, Department of Rehabilitative Services, Department of Social Services, ~~Department for Rights of Virginians With Disabilities,~~ Department of Medical Assistance Services, the Council on Indians, Governor's Employment and Training Department, Child Day-Care Council, Virginia Department for the Deaf and Hard-of-Hearing, and the Virginia Council on Coordinating Prevention. The Governor may, by executive order, assign any other state executive agency to the Secretary of Health and Human Resources, or reassign any agency listed above to another secretary.

§ 2.1-116. Certain officers and employees exempt from chapter.

The provisions of this chapter shall not apply to:

1. Officers and employees for whom the Constitution specifically directs the manner of selection;

2. Officers and employees of the Supreme Court and the Court of Appeals;

3. Officers appointed by the Governor, whether confirmation by the General Assembly or by either house thereof is required or not;

4. Officers elected by popular vote or by the General Assembly or either house thereof;

5. Members of boards and commissions however selected;

6. Judges, referees, receivers, arbiters, masters and commissioners in chancery, commissioners of accounts, and any other persons appointed by any court to exercise judicial functions, and jurors and notaries public;

7. Officers and employees of the General Assembly and persons employed to conduct temporary or special inquiries, investigations, or examinations on its behalf;

8. The presidents, and teaching and research staffs of state educational institutions;

9. Commissioned officers and enlisted personnel of the national guard and the naval militia;

10. Student employees in institutions of learning, and patient or inmate help in other state institutions;

11. Upon general or special authorization of the Governor, laborers, temporary employees and employees compensated on an hourly or daily basis;

12. County, city, town and district officers, deputies, assistants and employees;

13. The employees of the Virginia Workers' Compensation Commission;

14. The officers and employees of the Virginia Retirement System;

15. Employees whose positions are identified by the State Council of Higher Education and the boards of the Virginia Museum of Fine Arts, the Science Museum of Virginia, the Jamestown-Yorktown Foundation, the Frontier Culture Museum of Virginia, the Virginia Museum of Natural History and The Library of Virginia, and approved by the Director of the Department of Personnel and Training as requiring specialized and professional training;

16. Employees of the State Lottery Department;

17. Production workers for the Virginia Industries for the Blind Sheltered Workshop programs;

18. [Repealed.]

19. Employees of the Medical College of Virginia Hospitals Authority;

20. Employees of the University of Virginia Medical Center. Any changes in compensation plans for such employees shall be subject to the review and approval of the Board of Visitors of the University of Virginia. The University of Virginia shall ensure that its procedures for hiring University of Virginia Medical Center personnel are based on merit and fitness. Such employees shall remain subject to the provisions of Chapter 10.01 (§ 2.1-116.01 et seq.) of Title 2.1;

21. In executive branch agencies the employee who has accepted serving in the capacity of chief deputy, or equivalent, and the employee who has accepted serving in the capacity of a confidential assistant for policy or administration. An employee serving in either one of these two positions shall be deemed to serve on an employment-at-will basis. An agency may not exceed two employees who

serve in this exempt capacity;

22. Employees of Virginia Correctional Enterprises. Such employees shall remain subject to the provisions of Chapter 10.01 (§ 2.1-116.01 et seq.) of Title 2.1;

23. Officers and employees of the Virginia Port Authority; ~~and~~

24. Employees of the Virginia Higher Education Tuition Trust Fund*; and*

25. The Director of the Virginia Office for Protection and Advocacy.

§ 2.1-122. Employment of special counsel generally.

No special counsel shall be employed for or by the Governor or any state department, institution, division, commission, board, bureau, agency, entity, official, justice of the Supreme Court, or judge of any circuit court or district court except in the following cases:

(a) Where because of the nature of the service to be performed, the Attorney General's office is unable to render same, the Governor after issuing an exemption order stating with particularity the facts and reasons upon which he bases his conclusion that the Attorney General's office is unable to render such service, may employ special counsel to render such service as the Governor may deem necessary and proper.

(b) In cases of legal services in civil matters to be performed for the Commonwealth, where it is impracticable or uneconomical for the Attorney General to render same, he may employ special counsel whose compensation shall be paid out of the appropriation for the Attorney General's office.

(c) In cases of legal services in civil matters to be performed for any state department, institution, division, commission, board, bureau, agency, entity, official, justice of the Supreme Court, or judge of any circuit court or district court where it is impracticable or uneconomical for the Attorney General's office to render same, special counsel may be employed but only upon the written recommendation of the Attorney General, who shall approve all requisitions drawn upon the Comptroller for warrants as compensation for such special counsel before the Comptroller shall have authority to issue such warrants.

(d) In cases where the Attorney General certifies to the Governor that it would be improper for the Attorney General's office to render legal services due to a conflict of interests, or that he is unable to render certain legal services, the Governor may employ special counsel or other assistance to render such services as may be necessary.

(e) In cases of legal services in civil matters to be performed by the Virginia Office for Protection and Advocacy pursuant to Chapter 8.1 (§ 51.5-39.1 et seq.) of Title 51.5.

§ 2.1-373.13. Public Guardian and Conservator Advisory Board created; duties; membership; terms.

There is hereby created the Public Guardian and Conservator Advisory Board (the Board) which shall report to and advise the Commissioner on the means for effectuating the purposes of this article and shall assist in the coordination and management of the local and regional programs appointed to act as public guardians and conservators pursuant to Chapter 4 (§ 37.1-128.01 et seq.) of Title 37.1. The Board shall provide advice and counsel on the provision of high quality guardianship service and avoidance of conflicts of interest, promote the mobilization of activities and resources of public and private sector entities to effectuate the purposes of this article, and make recommendations regarding appropriate legislative and executive actions, including, but not limited to, recommendations governing alternatives for local programs to follow upon repeal of the authority granted to the courts pursuant to § 37.1-134.19 to appoint the sheriff as guardian or conservator when the maximum staff to client ratio of the local program is met or exceeded.

The Board shall consist of no more than fifteen members who shall be appointed by the Governor as follows: one representative of the Virginia Guardianship Association; one representative of the Virginia Area Agencies on Aging, one representative of the Virginia State Bar, one active or retired circuit court judge upon recommendation of the Chief Justice of the Supreme Court, one representative of the Association of Retarded Citizens, one representative of the Virginia Alliance for the Mentally Ill, one representative of the Virginia League of Social Service Executives, one representative of the Association of Community Service Boards, the Commissioner of the Department of Social Services or his designee, the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services or his designee, the Director of the Virginia ~~Department for the Rights of Virginians with Disabilities~~ *Office for Protection and Advocacy* or his designee, and one person who is a member of the Governor's Advisory Board for the Department for the Aging and

such other individuals who may be qualified to assist in the duties of the Board.

The Commissioners of the Departments of Social Services and Mental Health, Mental Retardation and Substance Abuse Services or their designees, the Director of the Virginia ~~Department for the Rights of Virginians with Disabilities~~ *Office for Protection and Advocacy* or his designee, and the representative of the Board for the Department for the Aging, shall serve terms coincident with their terms of office or in the case of designees, the term of the Commissioner or Director. Of the other members of the Board, five of the appointees shall serve for four-year terms and the remainder shall serve for three-year terms. No member shall serve more than two successive terms. A vacancy occurring other than by expiration of term shall be filled for the unexpired term. Each year, the Board shall elect a chairman and a vice-chairman from among its members. Five members of the Board shall constitute a quorum. Members shall receive no compensation for their services but shall be reimbursed for all reasonable and necessary expenses incurred in the discharge of their duties as members of the Board.

§ 2.1-703.1. Interagency Coordinating Council on Housing for the Disabled.

There shall be an Interagency Coordinating Council on Housing for the Disabled, hereinafter referred to as "Council." The Council shall consist of one representative, to be appointed by the agency executive, from each of the following: Department of Professional and Occupational Regulation, Department of Housing and Community Development, Virginia Housing Development Authority, ~~Department for Rights of Virginians With Disabilities~~ *Virginia Office for Protection and Advocacy*, Department for the Aging, Department for the Deaf and Hard-of-Hearing, Department of Mental Health, Mental Retardation and Substance Abuse Services, Department of Rehabilitative Services, Department of Social Services and Department for the Visually Handicapped. The Secretary of Commerce and Trade and Secretary of Health and Human Resources shall serve ex officio on the Council. The appropriate agency executive may appoint additional members as required. The Council shall annually elect a chairman. Each agency shall contribute a pro rata share of the required support services.

The Council shall provide and promote cross-secretariat interagency leadership for comprehensive planning and coordinated implementation of proposals to increase and maximize use of existing low-income housing for the disabled and to ensure development of accompanying community support services. The Council shall stimulate action by government agencies and enlist the cooperation of the nonprofit and private sectors. The Council shall develop a state policy on housing for the disabled for submission to the Governor. The policy shall be reviewed and updated as necessary. The Council shall submit to the Governor and various agency executives a report and recommendations at least annually.

§ 2.1-762. Early intervention agencies committee.

An early intervention agencies committee shall be established to ensure the implementation of a comprehensive system for early intervention services. The committee shall be composed of the Commissioner of the Department of Health, the Director of the Department for the Deaf and Hard-of-Hearing, the Superintendent of Public Instruction, the Director of the Department of Medical Assistance Services, the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services, the Commissioner of the Department of Social Services, the Commissioner of the Department for the Visually Handicapped, the Director of the ~~Department for Rights of Virginians with Disabilities~~ *Virginia Office for Protection and Advocacy*, and the Commissioner of the Bureau of Insurance within the State Corporation Commission. The committee shall meet at least twice each fiscal year and shall make annual recommendations to the Secretary of Health and Human Resources and the Secretary of Education on issues that require interagency planning, financing, and resolution. Each member of the committee shall appoint a representative from his agency to serve on the Virginia Interagency Coordinating Council.

§ 9-271. Comprehensive Prevention Plan.

A Comprehensive Prevention Plan shall be jointly developed biennially by the following agencies:

Department for the Aging, Department of Alcoholic Beverage Control, Department of Correctional Education, Department of Corrections, Department of Juvenile Justice, Department of Criminal Justice Services, Department of Education, Department of Health, Department of Medical Assistance Services, Department of Mental Health, Mental Retardation and Substance Abuse Services, Department of

Motor Vehicles, ~~Department for Rights of Virginians With Disabilities~~ *Virginia Office for Protection and Advocacy*, and Department of Social Services. The Secretary of Health and Human Resources shall designate an agency to coordinate development of the Plan. The Comprehensive Prevention Plan shall coordinate and integrate the planning efforts of the state agencies listed above and the private sector in order to provide a broad prevention agenda for the Commonwealth, enable communities to design and implement prevention programs that meet the identified needs of the community and facilitate the development of interagency and broad-based community involvement in the development of prevention programs. The Comprehensive Prevention Plan shall identify priority prevention issues and challenges, prevention goals and objectives and public and private strategies to achieve goals and objectives. For the purposes of the Plan, prevention activities, issues and programs shall be those activities which promote the objective identified in subsection B of § 9-270. The Plan with a cost analysis of the proposed strategies shall be submitted to the House Committee on Health, Welfare and Institutions and the Senate Committees on Rehabilitation and Social Services and Education and Health for the purpose of analysis, review and comment prior to implementation.

§ 9-323. Specialized Transportation Technical Advisory Committee.

A Specialized Transportation Technical Advisory Committee shall assist the Council. The Committee shall be composed of representatives from the following agencies: the Department for the Aging, the Department for the Deaf and Hard-of-Hearing, the Department of Education, the Department of Medical Assistance Services, the Department of Mental Health, Mental Retardation and Substance Abuse Services, the ~~Department for Rights of Virginians with Disabilities~~ *Virginia Office for Protection and Advocacy*, the Department of Rehabilitative Services, the Department of Social Services, the Department of Transportation's Directorate of Rail and Public Transportation or its successor agency and the Department for the Visually Handicapped and three representatives of public transportation providers or transportation district commissions to be appointed by the Council.

§ 51.5-1. Declaration of policy.

It is the policy of this Commonwealth to encourage and enable persons with disabilities to participate fully and equally in the social and economic life of the Commonwealth and to engage in remunerative employment. To these ends, the General Assembly directs the Governor, ~~Department for Rights of Virginians with Disabilities,~~ *Virginia Office for Protection and Advocacy,* Department for the Aging, Department for the Deaf and Hard-of-Hearing, Department of Education, Department of Health, Department of Housing and Community Development, Department of Mental Health, Mental Retardation and Substance Abuse Services, Board for Rights of Virginians with Disabilities, Department of Rehabilitative Services, Department of Social Services, Department for the Visually Handicapped, and such other agencies as the Governor deems appropriate, to provide, in a comprehensive and coordinated manner which makes the best use of available resources, those services necessary to assure equal opportunity to persons with disabilities in the Commonwealth.

The provisions of this title shall be known and may be cited as "The Virginians With Disabilities Act."

§ 51.5-2. Plan of cooperation.

The ~~Department for Rights of Virginians with Disabilities,~~ *Virginia Office for Protection and Advocacy,* Department for the Aging, Department for the Deaf and Hard-of-Hearing, Department of Education, Department of Health, Department of Housing and Community Development, Department of Mental Health, Mental Retardation and Substance Abuse Services, Department of Rehabilitative Services, Department of Social Services, Department for the Visually Handicapped and such other agencies as are designated by the Governor which serve persons with disabilities shall formulate a plan of cooperation in accordance with the provisions of this title and the federal Rehabilitation Act. The goal of this plan shall be to promote the fair and efficient provision of rehabilitative and other services to persons with disabilities and to protect the rights of persons with disabilities.

The plan of cooperation shall include an annual update of budgetary commitment under the plan, specifying how many persons with disabilities, by type of impairment, will be served under the plan. The plan of cooperation shall include consideration of first pay provisions for entitlement programs of a cooperating agency. If entitlement services are part of a client's individualized written rehabilitation program or equivalent plan for services, funds shall be paid from the entitlement program when possible. The plan and budgetary commitments shall be reviewed by the respective boards of the

cooperating agencies, reviewed by the Virginia Board for People with Disabilities and submitted for approval to the appropriate secretaries within the Governor's Office before implementation.

CHAPTER 8.1.

PROTECTION AND ADVOCACY SERVICES.

§ 51.5-39.1. Definitions.

As used in this chapter, unless the context requires a different meaning:

"Abuse" means any act or failure to act by an employee of a facility or program rendering care or treatment to individuals with mental, cognitive, sensory, physical or other disabilities that was performed or was failed to be performed knowingly, recklessly, or intentionally, and that caused or might have caused physical or psychological harm, injury, or death to a person receiving care or treatment for mental, cognitive, sensory, physical or other disabilities. Examples of abuse include, but are not limited to, acts such as:

1. Rape, sexual assault, or other criminal sexual behavior;

2. Assault or battery;

3. Use of language that demeans, threatens, intimidates or humiliates the person;

4. Misuse or misappropriation of the person's assets, goods, or property;

5. Use of excessive force when placing a person in physical or mechanical restraint;

6. Use of physical or mechanical restraints on a person that is not in compliance with federal and state laws, regulations, and policies, professionally accepted standards of practice or the person's individualized services plan; and

7. Use of more restrictive or intensive services or denial of services to punish the person or that is not consistent with his individualized services plan.

"Board" means the Board for Protection and Advocacy.

"Disabilities" means mental, cognitive, sensory, physical, or other disabilities covered by the federal Protection and Advocacy for Individuals with Mental Illness Act, the federal Developmental Disabilities Assistance and Bill of Rights Act, the federal Rehabilitation Act of 1973, as amended, and such other related federal and state programs as may be established by federal and state law.

"Neglect" means failure by an individual, program or facility responsible for providing services to provide nourishment, treatment, care, goods, or services necessary to the health, safety or welfare of a person receiving care or treatment for mental, cognitive, sensory, physical or other disabilities.

"Office" means the Virginia Office for Protection and Advocacy.

§ 51.5-39.2. The Virginia Office for Protection and Advocacy established; governing board; terms.

A. The Department for Rights of Virginians with Disabilities is hereby reestablished as an independent state agency, the Virginia Office for Protection and Advocacy. The Office is designated as the agency to protect and advocate for the rights of persons with mental, cognitive, sensory, physical or other disabilities and to receive federal funds on behalf of the Commonwealth of Virginia to implement the federal Protection and Advocacy for Individuals with Mental Illness Act, the federal Developmental Disabilities Assistance and Bill of Rights Act, the federal Rehabilitation Act, the Virginians with Disabilities Act and such other related programs as may be established by state and federal law. Notwithstanding any other provision of law, the Office shall be independent of the Office of the Attorney General and shall have the authority, pursuant to § 2.1-122 (e), to employ and contract with legal counsel to carry out the purposes of this chapter and to employ and contract with legal counsel to advise and represent the Office, to initiate actions on behalf of the Office, and to defend the Office, its officers, agents and employees in the course and scope of their employment or authorization, in any matter, including state, federal and administrative proceedings. Compensation for legal counsel shall be paid out of the funds appropriated for the administration of the Office. However, in the event defense is provided under Article 5.1 (§ 2.1-526.1 et seq.) of Chapter 32 of Title 2.1, counsel shall be appointed pursuant to § 2.1-122 (d). The Office shall provide ombudsman, advocacy and legal services to persons with disabilities who may be represented by the Office. The Office is authorized to receive and act upon complaints concerning discrimination on the basis of disability, abuse and neglect or other denial of rights, and practices and conditions in institutions, hospitals, and programs for persons with disabilities, and to investigate complaints relating to abuse and neglect or other violation of the rights of persons with disabilities in proceedings under state or federal law, and to initiate any proceedings to secure the rights of such persons.

B. The Office shall be governed by an thirteen-member board. The Board shall be composed of members who broadly represent or are knowledgeable about the needs of persons with disabilities served by the Office. Two or more members shall have experience in the fields of developmental disabilities and mental health. Persons with mental, cognitive, sensory or physical disabilities or family members, guardians, advocates, or authorized representatives of such persons shall be included. No elected official shall serve on the Board. No current employee of the Departments of Mental Health, Mental Retardation and Substance Abuse Services, Social Services, Health, Rehabilitative Services or for the Visually Handicapped or a community services board, behavioral health authority, or local government department with a policy-advisory community services board shall serve as a member. In appointing the members of the Board, consideration shall be given to persons nominated by statewide groups that advocate for the physically, developmentally and mentally disabled. The Governor and General Assembly shall not be limited in their appointments to persons so nominated; however, the Governor and General Assembly shall seriously consider the persons nominated and appoint such persons whenever feasible.

C. The Governor shall appoint seven members of the Board who shall be confirmed by the affirmative vote of a majority of those voting in each house of the General Assembly. The Speaker of the House of Delegates shall appoint three members, and the Senate Committee on Privileges and Elections shall appoint three members of the Board. The Board appointments shall be made to give representation insofar as feasible to various geographic areas of the Commonwealth.

D. For the initial term of the Board, the schedule below shall be followed:

1. One gubernatorial appointee and one legislative appointee shall be appointed for a term of one year;

2. Two gubernatorial appointees and one legislative appointee shall be appointed for a term of two years;

3. Two gubernatorial and two legislative appointees shall be appointed for a term of three years;

4. Two gubernatorial and two legislative appointees shall be appointed for a term of four years.

Thereafter, members shall be appointed for four-year terms.

E. Appointments to fill vacancies shall be for the unexpired terms. A vacancy of a legislatively appointed member shall be filled by either the Speaker of the House or Delegates or the Senate Committee on Privileges and Elections, and any such appointee shall enter upon and continue in office, subject to confirmation at the next session of the General Assembly. If the General Assembly fails to confirm his appointment, such person shall not be eligible for reappointment. Members shall continue to serve until such time as their successors have been appointed and duly qualified to serve.

F. A member who has been appointed to a four-year term shall not be eligible for reappointment during the two-year period beginning on the date on which such four-year term expired. However, upon the expiration of an appointment to an unexpired term, or an appointment described in subdivision D 1, 2, or 3 of this section, a member may be reappointed to a four-year term.

G. The Board shall elect a chairman and a vice-chairman from its members and appoint a secretary who may or may not be a member of the Board. A majority of the members of the Board shall constitute a quorum. The chairman shall preside over meetings of the Board and perform additional duties as may be set by resolution of the Board.

H. The Board shall meet at least four times each year. Members shall be reimbursed for their necessary and actual expenses incurred in the performance of their official duties.

I. Members of the Board shall be subject to removal from office only as set forth in Article 7 (§ 24.2-230 et seq.) of Chapter 2 of Title 24.2. The Circuit Court of the City of Richmond shall have exclusive jurisdiction over all proceedings for such removal.

§ 51.5-39.3. Application of State and Local Government Conflict of Interests Act.

The provisions of the State and Local Government Conflict of Interests Act (§ 2.1-639.1 et seq.) shall apply to the members of the Board and employees of the Office.

§ 51.5-39.4. Powers and duties of the Office.

The Office shall have the following powers and duties:

1. To monitor the implementation of Chapter 9 (§ 51.5-40 et seq.) of this title and to render assistance to persons with disabilities in the protection of their rights under the laws of the Commonwealth and of the United States.

2. To exhaust in a timely manner all appropriate administrative remedies to resolve complaints concerning violations of rights of persons with disabilities, when those rights are related to such disabilities. When such procedures fail or if, in pursuing administrative remedies, the Office determines that any matter with respect to an individual with a disability will not be resolved in a reasonable time, the Office shall have the authority to pursue legal and other alternative remedies to protect the rights of such persons.

3. To access during normal business hours and at other reasonable times all records relating to expenditures of state and federal funds or to the admission, care, treatment, habilitation, or provision of other services to individuals with disabilities, that are maintained by any state or local government department or agency, contractors of those departments or agencies, and any other entity or person providing services to a person with disabilities who may be represented by the Office, where such records relate to any complaint or investigation received by the Office. When such records contain personal identifying information about the person or persons, such information shall not be released nor shall the Office have access to it unless, he or they, or his or their designated representative, consents to such release or access. However, there shall be no right of access to privileged communications pursuant to § 8.01-581.17.

4. To access any records maintained in computerized data banks of the state and local government departments or agencies, contractors of those departments or agencies, or any other entities or persons that provide services to a person who may be represented by the Office. When such records contain personal identifying information about the person or persons, such information shall not be released nor shall the Office have access to it unless he or they, or his or their designated representative, consents to such release or access. However, there shall be no right of access to privileged communications pursuant to § 8.01-581.17.

5. To access, during normal working hours, personnel of the state or local government departments or agencies, contractors of those departments or agencies, and other service-providing entities or persons providing services to a person with disabilities who may be represented by the Office.

6. To access, at any time, all persons with disabilities detained, hospitalized, institutionalized, or receiving services or who may be represented by the Office.

7. To monitor compliance with the human rights regulations promulgated pursuant to Article 3 (§ 37.1-84.1 et seq.) of Chapter 2 of Title 37.1.

§ 51.5-39.5. Powers and duties of the Board; protection and advocacy fund.

A. The Virginia Office for Protection and Advocacy shall be administered by the Board, whose powers and duties include but are not limited to:

1. Appointing and annually evaluating the performance of a director, who shall not be a member of the Board, to serve as the chief executive officer of the Virginia Office for Protection and Advocacy at the pleasure of the Board. The Director shall be a person qualified by knowledge, skills, and abilities to administer and direct the provision of protection and advocacy services regarding the rights of persons with disabilities.

2. Preparing and submitting a budget to the General Assembly for the operation of the Office and the Board.

3. Establishing general policies for the Office and advising and assisting the Director in developing annual program priorities.

4. Establishing annual program priorities of the Office.

5. Adopting regulations, policies and procedures and making determinations necessary to carry out the provisions of this chapter and Chapter 9 (§ 51.5-40 et seq.) of this title. The adoption of such regulations shall be consistent with the provisions of Article 2 (§ 9-6.14:7.1 et seq.) of the Administrative Process Act.

6. Monitoring and evaluating the operations of the Office.

7. Maintaining records of its proceedings and making such records available for inspection by the public.

8. To perform such acts necessary to carry out the provisions of this chapter.

B. The Board shall have the authority to apply for and accept gifts, donations, grants, and bequests on behalf of the Office from the United States government and agencies and instrumentalities

thereof and from any other source and to deposit all moneys received in the Protection and Advocacy Fund created pursuant to this subsection. To these ends, the Board shall have the power to comply with such conditions and execute such agreements as may be necessary, convenient or desirable, consistent with policies, rules, and regulations of the Board.

There is hereby created in the Department of the Treasury a special nonreverting fund which shall be known as the Protection and Advocacy Fund to be administered by the Board which consists of (i) gifts, donations, grants, and bequests on behalf of the Office from the United States government and agencies and instrumentalities thereof; (ii) such other funds as may be appropriated by the General Assembly from time to time, and designated for this Fund; (iii) funds from any other source; and (iv) all interest, dividends and appreciation which may accrue thereto. Any moneys remaining in the Fund at the end of a biennium shall not revert to the General Fund, but shall remain in the Fund.

The total costs for the operation and administration of the Office shall be funded from the Fund and shall be in such amount as provided in the general appropriation act.

§ 51.5-39.6. Powers and duties of Director.

The Director shall have the following duties and powers:

1. To supervise and manage the daily operations of the Office and to carry out such duties as provided in this section.

2. To employ such qualified staff, including ombudsmen, advocates and legal counsel, as shall be necessary for carrying out the purposes of this chapter and Chapter 9 (§ 51.5-40 et seq.) of this title. The Director shall appoint a legal director, subject to the approval of the Board, who shall be an attorney who is qualified by knowledge, skills and abilities to direct the provision of protection and advocacy legal services regarding the rights of persons with disabilities.

3. To make and enter into all contracts and agreements, subject to ratification by the Board, necessary or incidental to the performance of the Office's duties and the execution of its powers under this chapter, including, but not limited to, contracts with the United States, other states, and agencies and political subdivisions of the Commonwealth, consistent with policies, rules and regulations of the Board.

4. To advise and assist the Board in developing a budget.

5. To annually prepare a report of activities of the Board and Office and submit copies of the report to the Governor, the chairs of the Senate Committee on Education and Health, the House Committee on Health, Welfare and Institutions, and the House Appropriations and Senate Finance Committees, and make the report available to the public.

6. To prepare reports, at the direction of the Board, on compliance with the human rights regulations promulgated pursuant to Article 3 (§ 37.1-84.1 et seq.) of Chapter 2 of Title 37.1 and make such reports available to the public.

7. To exercise such powers and perform such duties as are assigned to him by the Board.

§ 51.5-39.7. Ombudsman services for persons with disabilities.

A. There is hereby created within the Office an ombudsman section. The Director shall establish procedures for receiving complaints and conducting investigations for the purposes of resolving and mediating complaints regarding any activity, practice, policy, or procedure of any hospital, facility or program operated, funded or licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services, the Department of Rehabilitative Services, the Department of Social Services, or other state or local agency, which is adversely affecting the health, safety, welfare, or civil or human rights of any person with mental, cognitive, sensory or physical disabilities. After initial investigation, the section may decline to accept any complaint it determines is frivolous or not made in good faith. The ombudsman section shall attempt to resolve the complaint at the lowest appropriate level, unless otherwise provided by law. The procedures shall require the section to:

1. Acknowledge the receipt of a complaint by sending written notice to the complainant within seven days after receiving the complaint.

2. When appropriate, provide written notice of a complaint to the Department of Mental Health, Mental Retardation and Substance Abuse Services or any other appropriate agency within seven days after receiving the complaint. The Department or agency receiving the complaint shall report its findings and actions no later than fourteen days after receiving the complaint.

3. Immediately refer a complaint made under this section to the Department of Mental Health,

Mental Retardation and Substance Abuse Services or any other appropriate governmental agency, whenever the complaint involves an immediate and substantial threat to the health or safety of a person with mental retardation, developmental disabilities, mental illness, or other disability. The Department or agency receiving the complaint shall report its findings and actions no later than forty-eight hours following its receipt of the complaint.

4. Within seven days after identifying a deficiency in the treatment of a person with a disability that is in violation of state or federal law or regulation, refer the matter in writing to the appropriate state agency. The state agency shall report on its findings and actions within seven days of receiving notice of the matter.

5. Advise the complainant and any person with a disability affected by the complaint, no more than thirty days after it receives the complaint, of any action it has taken and of any opinions and recommendations it has with respect to the complaint. The ombudsman section may request any party affected by the opinions or recommendations to notify the section, within a time period specified by the section, of any action the party has taken on its recommendations.

6. Any complaint not resolved through negotiation, mediation, or conciliation shall be referred by the ombudsman section to the Director or the Director's designee to determine whether further protection and advocacy services shall be provided by the Office.

B. The ombudsman section may make public any of its opinions or recommendations concerning a complaint, the responses of persons and governmental agencies to its opinions or recommendations, and any act, practice, policy, or procedure that adversely affects or may adversely affect the health, safety, welfare, or civil or human rights of a person with a disability, subject to the provisions of § 51.5-39.8.

C. The Office shall publicize its existence, functions, and activities, and the procedures for filing a complaint under this section, and send this information in written form to each provider of services to persons with disabilities, with instructions that the information is to be posted in a conspicuous place accessible to patients, residents, consumers, clients, visitors, and employees. The Office shall establish, maintain and publicize a toll-free number for receiving complaints.

§ 51.5-39.8. Confidentiality of records and communications of the Office.

A. All documentary and other evidence received or maintained by the Office or its agents in connection with specific complaints or investigations shall be confidential and not subject to the mandatory disclosure requirements of the Virginia Freedom of Information Act (§ 2.1-340 et seq.). However, access to one's own records shall not be denied unless otherwise prohibited by state or federal law.

B. Communications between employees and agents of the Office and its clients or individuals requesting its services shall be privileged, as if between attorney and client.

C. Notwithstanding the provisions of this section, the Office shall be permitted to:

1. Issue a public report of the results of an investigation of a complaint which does not release the identity of any complainant or any person with mental illness, mental retardation, developmental disabilities or other disability, unless (i) such complainant or person or his legal representative consents in writing to such disclosure or (ii) such disclosure is required by court order.

2. Report the results of an investigation to responsible investigative or enforcement agencies should an investigation reveal information concerning any hospital, facility or other entity, its staff or employees, warranting possible sanctions or corrective action. This information may be reported to agencies responsible for licensing or accreditation, employee discipline, employee licensing or certification, or criminal prosecution.

§ 51.5-39.9. Cooperative agreements with state agencies regarding advocacy services for their clients.

Notwithstanding the foregoing, state agencies providing services to persons with disabilities may develop and maintain advocacy, client assistance or ombudsman services for their clients, which services may be within the agency and independent of the Office. The Office may enter into cooperative agreements with any state agency providing advocacy, client assistance, or ombudsman services for the agencies' clients, in order to assure the protection of and advocacy for persons with disabilities, provided that such agreements do not restrict such authority as the Office may otherwise have to pursue any legal or administrative remedy on behalf of persons with disabilities.

§ 51.5-39.10. Immunity.

Any person who in good faith complains to the Office on behalf of a person with a disability, or who provides information or participates in the investigation of any such complaint, shall have immunity from any civil liability and shall not be subject to any penalties, sanctions, restrictions or retaliation as a consequence of making such complaint, providing such information or participating in such investigation.

§ 51.5-39.11. Employees of the Virginia Office for Protection and Advocacy.

Except as otherwise provided by law, the employees of the Virginia Office for Protection and Advocacy shall be subject to the provisions of the Virginia Personnel Act (§ 2.1-116.01 et seq.).

§ 51.5-40. Nondiscrimination under state grants and programs.

No otherwise qualified person with a disability shall, on the basis of disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving state financial assistance or under any program or activity conducted by or on behalf of any state agency. The ~~Department for Rights of Virginians with Disabilities~~ *Virginia Office for Protection and Advocacy* shall promulgate such regulations as may be necessary to implement this section. Such regulations shall be consistent, whenever applicable, with regulations imposed under the federal Rehabilitation Act of 1973, as amended, and the federal Americans with Disabilities Act of 1990.

§ 51.5-46. Remedies.

A. Any circuit court having chancery jurisdiction and venue pursuant to Title 8.01, on the petition of any person with a disability, shall have the right to enjoin the abridgement of rights set forth in this chapter and to order such affirmative equitable relief as is appropriate and to award compensatory damages and to award to a prevailing party reasonable attorneys' fees, except that a defendant shall not be entitled to an award of attorneys' fees unless the court finds that the claim was frivolous, unreasonable or groundless, or brought in bad faith. Compensatory damages shall not include damages for pain and suffering. Punitive or exemplary damages shall not be awarded.

B. An action may be commenced pursuant to this section any time within one year of the occurrence of any violation of rights under this chapter. However, such action shall be forever barred unless such claimant or his agent, attorney or representative has commenced such action or has filed by registered mail a written statement of the nature of the claim with the potential defendant or defendants within 180 days of the occurrence of the alleged violation. Any liability for back pay shall not accrue from a date more than 180 days prior to the filing of the notice or bill of complaint and shall be limited to a total of 180 days, reduced by the amount of other earnings over the same period. The petitioner shall have a duty to mitigate damages.

C. The relief available for violations of this chapter shall be limited to the relief set forth in this section.

D. In any action in which the petitioner is represented by the ~~Department for Rights of Virginians With Disabilities~~ *Virginia Office for Protection and Advocacy*, no attorneys' fees shall be awarded, nor shall the ~~Department for Rights of Virginians With Disabilities~~ *Virginia Office for Protection and Advocacy* have the authority to institute any class action under this chapter.

§ 63.1-182.1. Rights and responsibilities of residents of adult care residences; certification of licensure.

A. Any resident of an adult care residence has the rights and responsibilities enumerated in this section. The operator or administrator of an adult care residence shall establish written policies and procedures to ensure that, at the minimum, each person who becomes a resident of the adult care residence:

1. Is fully informed, prior to or at the time of admission and during the resident's stay, of his rights and of all rules and expectations governing the resident's conduct, responsibilities, and the terms of the admission agreement; evidence of this shall be the resident's written acknowledgment of having been so informed, which shall be filed in his record;

2. Is fully informed, prior to or at the time of admission and during the resident's stay, of services available in the residence and of any related charges; this shall be reflected by the resident's signature on a current resident's agreement retained in the resident's file;

3. Unless a committee or conservator has been appointed, is free to manage his personal finances

and funds regardless of source; is entitled to access to personal account statements reflecting financial transactions made on his behalf by the residence; and is given at least a quarterly accounting of financial transactions made on his behalf when a written delegation of responsibility to manage his financial affairs is made to the residence for any period of time in conformance with state law;

4. Is afforded confidential treatment of his personal affairs and records and may approve or refuse their release to any individual outside the residence except as otherwise provided in law and except in case of his transfer to another care-giving facility;

5. Is transferred or discharged only when provided with a statement of reasons, or for nonpayment for his stay, and is given reasonable advance notice; upon notice of discharge or upon giving reasonable advance notice of his desire to move, shall be afforded reasonable assistance to ensure an orderly transfer or discharge; such actions shall be documented in his record;

6. In the event a medical condition should arise while he is residing in the residence, is afforded the opportunity to participate in the planning of his program of care and medical treatment at the residence and the right to refuse treatment;

7. Is not required to perform services for the residence except as voluntarily contracted pursuant to a voluntary agreement for services which states the terms of consideration or remuneration and is documented in writing and retained in his record;

8. Is free to select health care services from reasonably available resources;

9. Is free to refuse to participate in human subject experimentation or to be party to research in which his identity may be ascertained;

10. Is free from mental, emotional, physical, sexual, and economic abuse or exploitation; is free from forced isolation, threats or other degrading or demeaning acts against him; and his known needs are not neglected or ignored by personnel of the residence;

11. Is treated with courtesy, respect, and consideration as a person of worth, sensitivity, and dignity;

12. Is encouraged, and informed of appropriate means as necessary, throughout the period of stay to exercise his rights as a resident and as a citizen; to this end, he is free to voice grievances and recommend changes in policies and services, free of coercion, discrimination, threats or reprisal;

13. Is permitted to retain and use his personal clothing and possessions as space permits unless to do so would infringe upon rights of other residents;

14. Is encouraged to function at his highest mental, emotional, physical and social potential;

15. Is free of physical or mechanical restraint except in the following situations and with appropriate safeguards:

a. As necessary for the residence to respond to unmanageable behavior in an emergency situation which threatens the immediate safety of the resident or others;

b. As medically necessary, as authorized in writing by a physician, to provide physical support to a weakened resident;

16. Is free of prescription drugs except where medically necessary, specifically prescribed, and supervised by the attending physician;

17. Is accorded respect for ordinary privacy in every aspect of daily living, including but not limited to the following:

a. In the care of his personal needs except as assistance may be needed;

b. In any medical examination or health related consultations the resident may have at the residence;

c. In communications, in writing or by telephone;

d. During visitations with other persons;

e. In the resident's room or portion thereof; residents shall be permitted to have guests or other residents in their rooms unless to do so would infringe upon the rights of other residents; staff may not enter a resident's room without making their presence known except in an emergency or in accordance with safety oversight requirements included in regulations of the State Board of Social Services;

f. In visits with his spouse; if both are residents of the residence they are permitted but not required to share a room unless otherwise provided in the residents' agreements;

18. Is permitted to meet with and participate in activities of social, religious, and community

groups at his discretion unless medically contraindicated as documented by his physician in his medical record.

B. If the resident is unable to fully understand and exercise the rights and responsibilities contained in this section, the residence shall require that a responsible individual, of the resident's choice when possible, designated in writing in the resident's record, be made aware of each item in this section and the decisions which affect the resident or relate to specific items in this section; a resident shall be assumed capable of understanding and exercising these rights unless a physician determines otherwise and documents the reasons for such determination in the resident's record.

C. The residence shall make available in an easily accessible place a copy of these rights and responsibilities and shall include in them the name and telephone number of the regional licensing supervisor of the Department of Social Services as well as the toll-free telephone number for the Virginia Long-Term Care Ombudsman Program, any sub-state ombudsman program serving the area, and the toll-free number of the ~~Department for the Rights of Virginians With Disabilities~~ *Virginia Office for Protection and Advocacy.*

D. The residence shall make its policies and procedures for implementing this section available and accessible to residents, relatives, agencies, and the general public.

E. The provisions of this section shall not be construed to restrict or abridge any right which any resident has under law.

F. Each residence shall provide appropriate staff training to implement each resident's rights included in this section.

G. The State Board of Social Services shall promulgate regulations as necessary to carry out the full intent of this section.

H. It shall be the responsibility of the Commissioner of Social Services to ensure that the provisions of this section are observed and implemented by adult care residences as a condition to the issuance, renewal, or continuation of the license required by this article.

§ 63.1-314.8. Technical Assistance Committee created; duties; membership.

A. There is hereby created a Technical Assistance Committee, which shall provide technical and support services on the operations of the information and referral system as the Council may deem appropriate and shall advise the Council in performing its powers and duties.

B. The membership of the Technical Assistance Committee shall include but not be limited to:

1. Two directors of local departments of public welfare or social services, one serving a rural and one an urban locality, to be appointed by the Commissioner of Social Services; and

2. The Commissioners or Directors, or their designees, of the Department of Medical Assistance Services; Department of Health; Department of Mental Health, Mental Retardation and Substance Abuse Services; Department of Rehabilitative Services; Department for the Aging; Department for the Visually Handicapped; ~~Department for Rights of Virginians With Disabilities~~ *Virginia Office for Protection and Advocacy*; Department of Information Technology; Department for the Deaf and Hard-of-Hearing; Department of Health Professions; Department of Corrections; Department of Education; Department of Juvenile Justice; and the Virginia Employment Commission.

3. That Chapter 8 (§§ 51.5-36 through 51.5-39) of Title 51.5 of the Code of Virginia is repealed.

4. That the Governor is hereby requested to designate the Virginia Office for Protection and Advocacy as the agency accountable for the proper use of funds and conduct of the state Protection and Advocacy agency to administer the Protection and Advocacy for Individuals with Mental Illness Program, the Developmental Disabilities Program, the Client Assistance Program, the Assistive Technology Program and such other federal and state programs for the protection and advocacy of persons with mental, cognitive, sensory, physical, or other disabilities as determined by federal and state law.

5. That the provisions of this act shall not become effective until the Governor, pursuant to applicable federal statutes and regulations, completes the process for redesignation of the Virginia Office for Protection and Advocacy.

6. That the regulations of the Department for Rights of Virginians with Disabilities in effect on the effective date of this act shall continue in effect until such time as amended or repealed by the Virginia Office for Protection and Advocacy.

7. That the Governor may transfer an appropriation or any portion thereof or any employees

within an agency established, abolished or altered by the provisions of this act, or from one such agency to another, to support the changes in organization or responsibility resulting from or required by the provisions of this act.

8. That as of the effective date of this act, the Virginia Office for Protection and Advocacy shall be deemed the successor in interest to the Department for Rights of Virginians with Disabilities to the extent that this act transfers powers and duties. All right, title and interest in and to any real or tangible personal property vested in the Department for Rights of Virginians with Disabilities to the extent that this act transfers powers and duties as of the effective date of this act shall be transferred to and taken as standing in the name of the Virginia Office for Protection and Advocacy.

9. That the provisions of enactments 2 through 8 shall not become effective unless reenacted by the 2000 Session of the General Assembly.

APPENDIX VI-7

	Listing of HJR 225 Joint Subcommittee Recommendations
1	*That all persons living below the poverty level should have access to Medicaid coverage if they are categorically eligible and disabled as defined by the Social Security Administration. Steps should be taken in the form of incremental increases in the percentage of income covered by Medicaid up to 100 percent of the poverty level, subject to the Appropriation Act. This recommendation is intended to address the inequity in Medicaid income eligibility limits between Aged, Blind and Disabled individuals who receive Supplemental Security Income (SSI) and those Aged, Blind and Disabled individuals who receive their incomes from regular Social Security disability benefits or some other source. The projected state general fund (GF) cost and number of new recipients for each incremental increase in the percentage of the federal poverty level (FPL) are shown in the table below:*

Percent FPL	*Cost in Millions FY 2001*	*GF/New Eligibles FY2002*
100% =	*$26.7 (27,270)*	*$27.9 (28,624)*
95% =	*$21.3 (21,816)*	*$ 22.3 (22,899)*
90% =	*$16.0 (16,362)*	*$16.7 (17,174)*
85% =	*$10.7 (10,908)*	*$11.2 (11,450)*
80% =	*$ 5.3 (5,454)*	*$ 5.6 (5,725)*
75% =	*$ 3.3 (3,409)*	*$ 3.5 (3,578).*

2	*That the medically needy income limit be increased by the annual percentage change in the Consumer Price Index (CPI), retroactively to July 1, 1996, and subject to the Appropriation Act. This option would add 112 new eligible persons in Fiscal Year 2001 and 225 new persons in Fiscal Year 2002. The general and non-general fund costs, assuming a two- percent CPI adjustment each year, are shown in the table below:*	

	FY 2001	*FY 2002*
GF	*$475,205*	*$1,007,073*
NGF	*$510,902*	*$1,084,460*
TOTAL	*$986,107*	*$2,091,533.*

3	*That work should be encouraged and, therefore, consideration should be given to adopting the federal "buy-in" option to cover working disabled individuals with incomes up to 250 percent of the poverty level, consistent with coverage for other disability groups and subject to the Appropriation Act.*
4	*That the first-line use of the new antipsychotic medications should be supported and budget language should be adopted to eliminate preauthorization requirements for antipsychotic medications prescribed for Medicaid recipients, except where indicated for the safety of the patient. In lieu of preauthorization, budget language is recommended, directing the DMHMRSAS and Medical Assistance Services to develop a plan for retrospective review by HMOs of antipsychotic medications used by Medicaid recipients. The purpose of this recommendation is to increase access to the most effective antipsychotic medications available. The availability of atypical antipsychotic medications is instrumental in preventing the hospitalization and readmission of individuals with serious mental illness.*
5	*That budget language should be adopted to direct the DMHMRSAS and DMAS to develop a plan for statewide implementation of the PACT, including the identification of costs and cost offsets, general fund match, the necessary waivers, bundled reimbursement, clinical eligibility, rural area access, and the role of the private sector. Included in the plan should be standards that prescribe key elements of PACT treatment and rehabilitation practices: required staff mix and qualifications; minimum staff-to-client ratios; detailed outlines of required treatment; rehabilitation and support services, including assessment and planning; specifications for program operations; eligibility criteria to ensure that PACT services are provided to those in need; and accountability processes to ensure quality outcomes. The Departments shall report to the Chairmen of the House Appropriations and Senate Finance Committees by November 1, 2000.*

6	*That by letter from the Chairmen, an implementation plan and status report should be requested from the DMHMRSAS and DMAS on the recommendations in House Document 61.*
7	*That language should be included in the 2000-2002 biennium budget that requires action to separate care coordination and case management from service delivery in CSBs. The purpose of this recommendation is to increase consumer choice of providers and eliminate any perceived conflict of interest between these services.*
8	*That a resolution and budget language should be introduced in the 2000 Session of the General Assembly directing the Secretary of Health and Human Resources to establish an interagency task force to work in conjunction with consumers, families, advocates, community services boards, and private for-profit and non-profit community-based rehabilitation providers, to define roles and responsibilities of the agencies, streamline procedures, examine service definitions, and update the interagency agreement. The Secretary should report to the Governor and the 2001 General Assembly.*
9	*That by budget language, the DMHMRSAS and DMAS should be directed to develop for the 2001 Session of the General Assembly an integrated policy and plan, including the necessary implementing legislation and budget amendments, to provide and improve access by children to mental health and mental retardation services. The plan, integrating the DMHMRSAS, community services boards, court services, Comprehensive Services Act, and Medicaid, should identify: the services needed by children, the cost and source of funding for the services, the strengths and weaknesses of the current service delivery and administrative structure, and opportunities for improvement.*
10	*That two actions related to the 2000-2002 biennium budget are recommended: (i) By letter to the Governor, request an amendment to the 2000-2002 biennium budget in support of children and adolescent initiatives; (ii) By budget amendment and subject to the Appropriation Act, support the 2000-2002 budget initiatives from the DMHMRSAS, related to children and adolescents: $15.2 million (GF) in FY 2001 and $21.5 million (GF) in FY 2002. The request by the DMHMRSAS covers a range of services and initiatives to reduce waiting lists.*
11	*That, subject to the Appropriation Act, sufficient general funds ($5.1 million in FY 2002 and $10.1 million in 2002-2004 biennium) should be appropriated to draw down the maximum federal match funds projected for the following array of services: emergency services; outpatient (including intensive outpatient); targeted case management; day treatment; evaluation and assessment; and residential services for children. The funds should be appropriated in stages to accommodate the time required to develop and promulgate regulations through the federal and state process.*
12	*That the DMHMRSAS and DMAS should be directed to select the specific menu of services, which would be required to be available statewide. The purpose of this recommendation is to ensure that the DMHMRSAS, with its expertise in substance abuse treatment, participates in the selection and definition of covered services.*
13	*That, prior to implementation, the DMHMRSAS and DMAS should be directed to design a process for evaluating the costs and benefits, including cost offsets in other programs, of reimbursement by Medicaid and the Children's Medical Security Insurance Plan for substance abuse treatment in Virginia and require annual reports on findings to the Governor and the General Assembly. An initiative of this kind warrants a thorough evaluation process; however, it is not the intention of the joint subcommittee to delay implementation while an evaluation process is being designed. There are some design prototypes in other states and at the national level and the joint subcommittee requests that the Departments take advantage of the work that has already be accomplished to expedite development of our own design.*
14	*That a modified or Alternative Model III for structure and administration of financing should be adopted. The following paragraphs describe some of the essential features. (A staff paper that describes Alternative Model III in detail is included in Appendix VI-5).* *a) The model (partial carve-out) only applies to Medicaid State Plan Option, mental retardation home and community based waiver, and any other new or expanded mental health, mental retardation, and substance abuse services related to these SPO and mental retardation waiver services subsequently added to the list of covered Medicaid services. For the purposes of*

Alternative Model III, SPO services mean community mental health rehabilitation services, targeted mental health and mental retardation case management, substance abuse treatment for pregnant and postpartum women and intensive in-home and therapeutic day treatment for children and adolescent services in the EPSDT program.

b) Alternative Model III does not propose changes to existing arrangements for Medicaid funding of state mental health and mental retardation facilities. Medical/surgical inpatient psychiatric, outpatient clinic, and pharmacy services would remain with DMAS and the Medicaid Medallion II HMOs.

c) Subcontracted administration to the DMHMRSAS could include provider certification, service authorization (where appropriate, e.g., the mental retardation waiver), utilization review, data collection and analysis, and, subject to DMAS oversight and approval with respect to compliance with federal law, policy and regulatory development for Medicaid SPO, mental retardation home and community-based waiver, and any other new or expanded mental health, mental retardation, and substance abuse services related to these SPO and mental retardation waiver services subsequently added to covered Medicaid services. Some of these functions may be handled by an ASO under contract with the DMHMRSAS.

d) DMAS would continue to handle claims payment. Reimbursement for these carved-out services would continue to be on a fee-for-service basis. Capitation and risk sharing arrangements would not be used to fund these services.

e) CSBs would function as care coordinators, following specific practice guidelines developed by the DMHMRSAS, and as the single-point-of-entry into the services system for Medicaid SPO, mental retardation waiver, and any other new or expanded mental health, mental retardation, and substance abuse services related to these SPO and waiver services subsequently added to covered Medicaid services. Care coordination is the central service coordination function of CSBs in a managed system of care. Care coordination would be provided exclusively by CSBs and behavioral health authorities. The HJR 240 joint subcommittee recommended that CSBs and behavioral health authorities be local care coordinators and not the primary or only providers of services.

f) CSBs would also be responsible, through their performance contracts, for network development. Network development includes identifying or supporting and assisting the establishment of new service providers. This would increase and enhance consumer choice and address issues of "statewideness" and choice. Network development also includes assuring that all qualified private providers can participate in the publicly funded services system and are not excluded from consideration as consumers select providers. The performance contracts that the DMHMRSAS negotiates annually with CSBs would require CSBs and any contracted case managers to inform consumers of all qualified providers that are geographically accessible to them, support and facilitate active and unencumbered consumer choice among providers, and document these actions in the consumer's individual plan of care. Although CSBs are the single point of entry and accountability for the publicly funded mental health, mental retardation and substance abuse community services system, the contractual agreement should ensure that consumers' choices of qualified providers is not limited or constrained.

g) All current state funded match for Medicaid SPO and waiver services that has been transferred from the DMHMRSAS appropriation for community services to DMAS and is appropriated to DMAS as of June 30, 2000, would remain in the DMAS base budget.

h) On and after July 1, 2000, all additional match that may be needed for SPO and waiver services (above the amount already appropriated in the DMAS base budget) would be requested by DMAS during the budget development process and appropriated to DMAS by the General Assembly. General fund appropriations to the DMHMRSAS and subsequent transfers to DMAS for the following services would not occur: SPO and waiver match or any other new or

	expanded mental health, mental retardation, and substance abuse services related to these SPO and waiver services subsequently added to the list of covered Medicaid services. *i) To minimize possible adverse effects (either of under collections or over collections that DMAS would have to match) that might result from this change, the DMHMRSAS would closely analyze Medicaid fee collection trends during the last half of FY 2000 and make adjustments in each CSB's Medicaid fee allocations and state general fund allocations so that post year-end adjustments for state-funded match would be as small as possible.* *j) In addition, the DMHMRSAS would allow one final set of adjustments for FY 2000 state general funds for Medicaid federal funds match after the end of the fiscal year. These adjustments would minimize any possible "losses" of state funds for under collecting CSBs and the possible matching fund increases that DMAS would have to seek for CSBs that over collected their Medicaid allocations.* *k) While the overwhelming proportion of state matching funds for these services is already in the DMAS budget, the fiscal impact of this provision is difficult to project precisely. The impact should be minimal during the first year for SPO services, since private providers have not participated directly in this option to date. Therefore, there may be relatively little private provider participation, and thus growth, in FY 2001. DMAS and the DMHMRSAS should have sufficient information about the mental retardation waiver to be able to predict the need for additional match in the DMAS budget after July 1, 2000, since the waiver is capped at a preset capacity. The only demand for additional state funds for federal funds match in the DMAS budget should come from growth caused by providing currently covered services to additional Medicaid enrollees, providing covered SPO services not currently provided by the CSB or providing new services not previously covered by the State Medical Assistance Plan.*
15	*That local governments should be required to provide the same amount of local funds used to match state general fund allocations provided by the DMHMRSAS as they provided in the previous fiscal year. This requirement would not apply to services paid for solely with local government funds. Specifically, the following language is proposed for the Appropriation Act, Item 347: "Local governments shall not use state general, special, or federal trust funds provided in this item or state general, special, or federal trust funds provided in Item 335 for mental health, mental retardation, or substance abuse services to supplant their funding effort for mental health, mental retardation and substance abuse services existing as of June 30, 2000."*
16	*That language should be placed in the Appropriation Act concerning the forecasting of Medicaid utilization for the services contained in this partial Medicaid carve-out. The following language should be inserted at the appropriate places in the FY 2001 Appropriation Act: "The Department of Medical Assistance Services and Department of Planning and Budget, with the assistance of the DMHMRSAS, shall use their Medicaid expenditure forecast models to project expenditures for SPO, mental retardation home and community-based waiver, and any other related new or expanded mental health, mental retardation, and substance abuse services related to these SPO and waiver services subsequently added to the list of covered Medicaid services."*
17	*That language should be included in the current biennium budget that directs the DMHMRSAS and DMAS to describe their current operational and policy relationships and their plan for implementing Alternative Model III. The Departments should report to the Chairmen of the House Committee on Appropriations and the Senate Committee on Finance by April 28, 2000.*
18	*That language should be included in the Appropriation Act that directs DMAS to provide claims and expenditure data to the DMHMRSAS about all Medicaid-reimbursed services and information about the recipients of those services. Services include SPO, mental retardation home and community-based waiver, any new or expanded mental health, mental retardation, and substance abuse services related to these SPO and Waiver services subsequently added to covered Medicaid services, medical/surgical inpatient psychiatric, outpatient clinic, and any other behavioral health and mental retardation habilitation services. The ASO contracted by the DMHMRSAS could use this information to increase the effectiveness and efficiency of the services system.*

19	*That the adequacy of staffing for the Office of Human Rights and its oversight of advocates must be evaluated to assess its capacity to carry out, not only its complaint processing function, but also to engage in education and training on human rights protections statewide in the programs and in the communities to increase awareness of the internal rights protections systems. The DMHMRSAS should provide adequate resources for the Office of Human Rights to provide appropriate oversight of the internal human rights program.*
20	*That the number, qualifications, competencies, and service of state facility advocates and regional advocates in the Commonwealth must be evaluated to assure that each consumer in a state facility or community program has sufficient access, in terms of timeliness, geography, cultural competence, and communication modalities (e.g., nonverbal speech), to a knowledgeable and skilled advocate. These advocates should be recruited, hired, trained, and supervised by Office of Human Rights personnel.*
21	*That statewide outreach to consumers must be increased and public awareness campaigns must be conducted regarding human rights protections for people with disabilities. Community outreach should help with recruitment of volunteers for the LHRCs. LHRCs and regional advocates must have enhanced roles, and perhaps greater funding to effectuate those roles. The human rights regulations should be revised to require consolidation of CSB, private provider, and community facility LHRCs into regional committees as recommended by House Document 77. All SHRC and LHRC members should be reimbursed for expenses incurred in the discharge of their duties. There should be at least twice-yearly meetings between the state facility LHRC and the regional community LHRCs sending patients to that facility.*
22	*That the implementation of the new human rights regulations should be reviewed by a legislative oversight body for an additional two years to assess their adequacy and effectiveness in assuring and protecting the human rights of every client and consumer in facilities and programs operated, licensed or funded by the DMHMRSAS.*
23	*That the new protection and advocacy agency needs to demonstrate that it has the autonomy and authority to perform its protection and advocacy functions. This should be done by removing the department from the executive branch and creating an independent state agency. The new protection and advocacy agency should have a governing board that is composed of gubernatorial and legislative appointees with staggered terms. It should be governed by an eleven-member board. The appointments should be representative of the state's geographic regions. The Governor should appoint three members of the board who shall be confirmed by the General Assembly. The Speaker of the House of Delegates should appoint four members, and the Senate Committee on Privileges and Elections should appoint four members of the board. The board composition, three gubernatorial and eight legislative appointments, complies with federal law. The governing board should hire the agency director, who, in turn, should retain legal counsel.*
24	*That the protection and advocacy agency needs increased legal authority to obtain access to facilities and programs, protect the confidentiality of its records and receive notification of critical incident information from the internal human rights system administered by the DMHMRSAS. This will enable the new P&A agency to monitor conditions in facilities and programs, conduct investigations regarding alleged violations of rights that have not been addressed satisfactorily by the internal system, and monitor the operations and effectiveness of the internal system.*
25	*That the new protection and advocacy agency needs to maximize its use of resources by having an advocacy program focused on systemic change and consumer education. It needs to build coalitions with constituent groups that are working on similar issues and increase its visibility with respect to state-level policy and legislative initiatives..*
26	*That the General Assembly should provide sufficient resources to expand the new P&A agency's capacity for attorney representation of clients, increase staff (advocates, attorneys, and management) visits to facilities and programs to ensure an ongoing presence statewide, and address systemic human rights issues at the policy and legislative levels. Attorneys and all staff should have regular and direct client contact. It is questionable if any protection and advocacy agency can initiate substantive litigation when only using contracted attorneys. Therefore, the number of staff attorneys should be increased significantly.*
27	*That the new protection and advocacy agency should establish an advocacy or ombudsmen statutory program for receiving complaints and conducting investigations for the purpose of mediating and*

	resolving consumer complaints that are not resolved by the internal system. This would offer an extrajudicial route to address issues and prevent potential over reliance on litigation.
28	*That PAIMI Program resources be expanded in order to allow the new protection and advocacy agency to provide protection and advocacy for persons with mental illness who are being released back into communities. CRIPA does not apply to non-institutional settings and the state's protection and advocacy will need to be strengthened to be a more effective and independent watchdog. Maximum employment level for the PAIMI Program would be increased by five for three attorney and two advocate positions for an approximate biennial total of $500,000.*
29	*That $395,341 for FY 2001 and $372,593 should be appropriated in FY 2002 to fund the new Ombudsman Division in the new Virginia Office for Protection and Advocacy. Maximum employment level would be increased by seven. DRVD included a request for such a division in its budget request to the Governor.*
30	*That DRVD's staffing and resource levels enable the agency to meet the current statewide need for protection and advocacy services. DRVD submitted a budget request to the Governor for two non-general fund full-time equivalent positions to hire a staff attorney in the Tidewater region and a program operations coordinator. Maximum employment level would be increased by two. Such positions would be funded through federal grant funds: $96,667 in FY 2001 and $104,772 in FY 2002.*
31	*That the DMHMRSASt and the CSBs continue to work together to provide a full array of appropriate services for the treatment of children and adolescents in need of mental health, mental retardation and substance abuse services and to ensure that these services are available to all children of the Commonwealth.*
32	*That the Chair of the CSA State Executive Council, supported by the Office of Comprehensive Services, shall examine the potential for use of underutilized state property under the control of the DMHMRSAS to determine whether the use of underutilized state property, leased to vendors, would reduce the cost of services in the provision of services under the Comprehensive Services Act (CSA), as authorized by the local Community Policy and Management Team (CPMT). If such arrangements are deemed feasible, with the approval of the General Assembly, then the State Executive Council shall take the lead and develop a contracting process with the DMHMRSAS for the leasing of underutilized property to vendors, and facilitate the use of those services through local CMTs.* *Because children are known to have better treatment outcomes when services are received close to home, and, because in some cases, families need treatment services as well, every attempt shall be made to locate these treatment facilities, if deemed feasible, in an appropriate geographic distribution across the state that allows all children and families to have reasonable access to services. In addition, every consideration shall be given to using the use of facility personnel who may have been subjected to downsizing with the new emphasis on community-based treatment when staffing such treatment facilities, as well as, when creating or capitalizing on regional efforts.*
33	*That the CSA State Executive Council shall move forthwith to select and implement a uniform data system for use by local CPMTs, the Department of Juvenile Justice, and appropriate state agencies as currently mandated by § 2.1-746 of the Code of Virginia. Such a system shall be in place no later than December 31, 2000. The Council shall take into consideration those smaller jurisdictions that because of their low caseloads, may not be required to participate in the computer system but are still required to utilize the same format for reporting purposes. The Council shall initially report their progress in implementing the system to the House Appropriations and the Senate Finance Committees by June 30, 2001 and shall report annually thereafter. Language should be developed for a budget amendment that will assist some localities in the purchase of hardware and programs (many localities have already purchased programs and are already online).*
34	*That the CSA State Executive Council, with the support of the Office of Comprehensive Services, shall develop criteria for providing additional state reimbursement for those children who must access costly treatment for specialized services. An initial report on the criteria shall be made to the House Appropriations and Senate Finance Committees in October 2000, and the Council shall make annual reports thereafter on the development of the criteria and recommendations for statutory language and budget requests.*

35	*That the joint subcommittee support the Department's recommendation that a pilot of a modified KOKAH be implemented in each of the health planning regions of the state. The KOKAH model should be modified to include less reliance on local inpatient hospitalization, a broader array of community-based diversion and step-down services, and standards for hospital utilization rates. A grant of flexible dollars should be awarded to each pilot site to purchase and implement an array of services, with an emphasis on community-based services and including purchase of local inpatient treatment. The development of standardized risk assessment and clinical guidelines to support decision-making regarding the use of local private facilities and state inpatient facilities is also recommended.*
36	*That the Department of Social Services, the DMHMRSAS, and other affected and participating agencies continue to expand the provision of substance abuse treatment services to TANF recipients, identify funding requirements for future biennia, propose any necessary statutory changes to implement such a program, and provide regular, intensive evaluation of program outcomes to the Governor and General Assembly.*
37	*That the DMHMRSAS, through its Comprehensive State Plan, should identify the numbers of individuals who need residential services, by type of population and service intensity, and the number and types of housing arrangements that would be needed to meet those needs, and, in accordance with § 37.1-48.1 of the Code of Virginia, use this information in preparation of its biennium budget submission to the Governor.*
38	*That the DMHMRSAS should continue and expand the use of individualized services plans, not only for state facility discharges of long term patients and residents, but also for new initiatives funded by the General Assembly.*
39	*That the DMHMRSAS should expand the use of supportive residential services to assist more consumers to obtain appropriate housing or to upgrade their existing housing arrangements. This might include a special initiative to provide rental subsidies for identified individuals in priority populations, as a part of their individualized services plans.*
40	*That the General Assembly should encourage the Virginia Housing and Development Authority (VHDA) to work closely with the DMHMRSAS to increase the flexibility of VHDA's loan programs, to make it easier for housing providers to make more housing available for mentally disabled populations.*
41	*That the General Assembly should encourage the Department of Housing and Community Development to work closely with the DMHMRSAS to identify and make available resources for increased low-income housing that could be occupied by persons with mental disabilities.*
42	*At this time, a capital fund to support the construction or acquisition of housing should not be established. Once the preceding recommendations are implemented fully, the need for additional housing stock could be re-examined if necessary.*
43	*That the ACR pilot projects continue to collect and evaluate outcome information and make recommendations back to the General Assembly regarding the possible expansion of such programs. CSBs are also encouraged to use funding, including Medicaid, to leverage funds to seek out and serve those eligible residents who have either been uninvolved or only marginally involved with services.*
44	*That the DSS revise its regulations regarding the licensing of adult care residences, regardless of size and population, to require not only a disaster plan but also evaluate such plan for its logistical determination for the relocation of patients, records, medication and other information vital to the safety and well-being of its clients in the event of an emergency.*
45	*That, in order to enhance the system of primary health care for persons with mental illness, mental retardation and substance abuse services, the Department of Health should pursue the following objectives:* • *To review medical capacity in CSBs, medical/surgical care in facilities and medical clearance for admission to state facilities. Assessment of the primary health care status of CSB and facility patients should be systematic and routine.* • *To solicit funding to further examine the actual gaps in primary health service delivery to the mental ill, mentally retarded and substance abuse population. This would involve the use of a consultant.* • *To study additional ways of assuring proper primary health care assessment of persons with*

	mental health, mental retardation, or substance abuse problems that require emergency hospitalization. *To incorporate more training on treating those with mental illness, mental retardation and substance abuse problems into the curriculum of medical students.*
46	*That the General Assembly create a legislative agency known as the Joint Commission on Behavioral Health Care, similar to the Joint Commission on Health Care, to provide oversight and attention to the needs of those persons needing mental health, mental retardation and substance abuse services and their families. The membership would be comprised of legislative members and citizens of the Commonwealth who would serve for set terms. The duties of the Commission would include the examination of state agency responsibilities; identification of innovations in other states and the private sector that can serve as models for Virginia; review and analysis of up-to-date research; and providing advice and assistance to the Commonwealth.*

APPENDIX VI-8

003949756

HOUSE JOINT RESOLUTION NO. 218

Offered January 24, 2000

Requesting the Secretary of Health and Human Resources to establish an interagency task force to work in conjunction with consumers, families, advocates, community services boards, and private for-profit and non-profit community-based rehabilitation providers, to examine implementation of the Medicaid home-and-community-based waiver for mental retardation services.

Patrons—Weatherholtz, Bloxom, Christian, DeBoer, Grayson, Hall, Morgan and Thomas; Senators: Hanger, Martin and Wampler

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Referred to Committee on Rules

WHEREAS, the 1998 Appropriation Act required the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) and the Department of Medical Assistance Services (DMAS) to study the "current Medicaid waiver for mental retardation services and possible changes that will lead to maximum service efficiencies and greater cost containment"; and

WHEREAS, their report, House Document 61, which was submitted to the Governor and the General Assembly on April 12, 1999, contains a number of findings and recommendations related to administration, array of services, service delivery and financial management of the mental retardation waiver; and

WHEREAS, House Document 61 recommends the formation of an interagency work group to "improve levels of understanding between the two agencies (DMHMRSAS and DMAS) and to streamline procedures for service authorization and quality monitoring"; and

WHEREAS, during the course of its work, the Joint Subcommittee to Evaluate the Future Delivery of Publicly Funded Mental Health, Mental Retardation and Substance Abuse Services (HJR 225, 1998) heard from many consumers, advocates and providers about the need to provide more flexibility in service definitions, simplify administration, and monitor quality in mental retardation waiver services; and

WHEREAS, the Joint Subcommittee recommended that the Secretary of Health and Human Resources establish an interagency task force to (i) update the understanding of roles and responsibilities, (ii) streamline procedures between DMHMRSAS and DMAS, (iii) improve service definitions to provide more flexibility and individualized supports, (iv) facilitate consumer access and choice of providers, and (v) develop a system for quality improvement and monitoring; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Secretary of Health and Human Resources establish an interagency task force to work in conjunction with consumers, families, advocates, community services boards, and private for-profit and non-profit community-based rehabilitation providers, to examine implementation of the Medicaid home-and-community-based waiver for mental retardation services. The task force shall consider, but is not limited to, (i) clarification of the roles and responsibilities of the agencies; (2) methods to simplify administration and streamline procedures; (3) service definitions for the purpose of providing more access, choice of providers, flexibility, individualized supports and encouraging work; and (4) updating the interagency agreement.

All agencies of the Commonwealth shall provide assistance to the Secretary of Health and Human Resources, upon request.

The Secretary of Health and Human Resources shall complete its work in time to submit its findings and recommendations to the Governor and the 2001 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

Official Use By Clerks

Agreed to By The House of Delegates		**Agreed to By The Senate**	
without amendment	☐	without amendment	☐
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐

Date: _____ Date: _____

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Clerk of the House of Delegates Clerk of the Senate

003947756

HOUSE JOINT RESOLUTION NO. 286

Offered January 24, 2000

Requesting the Department of Medical Assistance Services and the Department of Mental Health, Mental Retardation and Substance Abuse Services to study the feasibility of adopting the Medicaid "buy-in" option for people with disabilities whose earned income does not exceed 250 percent of the federal poverty guidelines.

Patrons—Grayson, Bloxom, Christian, DeBoer, Hall, Morgan, Thomas and Weatherholtz; Senators: Hanger and Wampler

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Referred to Committee on Rules

WHEREAS, Medicaid is an important source of health insurance for low-income aged, blind, and disabled people; and

WHEREAS, these groups of people often face barriers to private insurance coverage because they tend to require more health care and often more expensive types of care than other groups; and

WHEREAS, federal law requires that Medicaid programs cover certain aged, blind, and disabled persons, but states also have a variety of eligibility options; and

WHEREAS, lack of Medicaid coverage can impose substantial financial burdens on low income aged, blind, and disabled persons; and

WHEREAS, provisions of the federal Balanced Budget Act of 1997 and the Work Incentives Improvement Act of 1999 allow states to offer Medicaid "buy-in" options to workers with disabilities who would qualify for Medicaid if their incomes were not too high; and

WHEREAS, under the provisions of the federal law these workers would pay a premium based on a sliding scale, which would encourage work by allowing disabled individuals to earn more income while retaining Medicaid coverage; and

WHEREAS, encouraging work is consistent with the goal contained in the Governor's Strategic Plan, "Building Virginia's Future: A Time for All Virginians," to "continue Virginia's efforts to promote self-sufficiency for its citizens"; and

WHEREAS, the Joint Subcommittee to Evaluate the Future Delivery of Publicly Funded Mental Health, Mental Retardation and Substance Abuse Services (HJR 225 of 1998) recommended consideration of the Medicaid "buy-in" option to improve access to care by people with disabilities who are able to work and whose incomes do not exceed 250 percent of the federal poverty level; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Department of Medical Assistance Services and the Department of Mental Health, Mental Retardation and Substance Abuse Services study the feasibility of adopting the Medicaid "buy-in" option for people with disabilities whose earned income does not exceed 250 percent of the federal poverty guidelines. The study shall include an analysis of the costs and benefits of adopting the option, including an estimate of the number of people who might be helped to achieve self-sufficiency with this option, the cost to the Commonwealth, and the savings in other programs. The study shall also include a proposed plan for implementation, including the amount of individual premiums, the sliding payment scale, and an outreach program.

All agencies of the Commonwealth shall provide assistance to the Department of Medical Assistance Services and the Department of Mental Health, Mental Retardation and Substance Abuse Services for this study, upon request.

The Department of Medical Assistance Services and the Department of Mental Health, Mental Retardation and Substance Abuse Services shall complete their work in time to submit their findings and recommendations to the Governor and the 2001 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

Official Use By Clerks

Agreed to By The House of Delegates		**Agreed to By The Senate**	
without amendment	☐	without amendment	☐
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐

Date: _____ Date: _____

_____ _____

Clerk of the House of Delegates Clerk of the Senate

003701760

HOUSE BILL NO. 491

Offered January 18, 2000

A BILL to amend and reenact §§ 2.1-1.1, 2.1-1.3, 2.1-1.5, as it is currently effective and as it will become effective, 2.1-51.15, 2.1-116, 2.1-122, 2.1-373.13, 2.1-703.1, 2.1-762, 9-271, 9-323, 51.5-1, 51.5-2, 51.5-40, 51.5-46, 63.1-182.1 and 63.1-314.8 of the Code of Virginia; to amend the Code of Virginia by adding in Title 51.5 a chapter numbered 8.1, consisting of sections numbered 51.5-39.1 through 51.5-39.11; and to repeal Chapter 8 (§§ 51.5-36 through 51.5-39) of Title 51.5 of the Code of Virginia, relating to persons with mental retardation, developmental disabilities, or mental illness.

Patrons—Hamilton, Bloxom and DeBoer; Senators: Lambert and Newman

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Referred to Committee on Health, Welfare and Institutions

Be it enacted by the General Assembly of Virginia:

1. That §§ 2.1-1.1, 2.1-1.3, 2.1-1.5, as it is currently effective and as it will become effective, 2.1-51.15, 2.1-116, 2.1-122, 2.1-373.13, 2.1-703.1, 2.1-762, 9-271, 9-323, 51.5-1, 51.5-2, 51.5-40, 51.5-46, 63.1-182.1 and 63.1-314.8 of the Code of Virginia are amended and reenacted, and that the Code of Virginia is amended by adding in Title 51.5 a chapter numbered 8.1, consisting of sections numbered 51.5-39.1 through 51.5-39.11, as follows:

§ 2.1-1.1. Departments generally.

There shall be, in addition to such others as may be established by law, the following administrative departments of the state government:

Chesapeake Bay Local Assistance Department.
Department of Accounts.
Department for the Aging.
Department of Agriculture and Consumer Services.
Department of Alcoholic Beverage Control.
Department of Aviation.
Department of Business Assistance.
Department of Conservation and Recreation.
Department of Corporations.
Department of Correctional Education.
Department of Corrections.
Department of Criminal Justice Services.
Department for the Deaf and Hard-of-Hearing.
Department of Education.
Department of Emergency Services.
Department of Employee Relations Counselors.
Department of Environmental Quality.
Department of Fire Programs.
Department of Forestry.
Department of Game and Inland Fisheries.
Department of General Services.
Department of Health.
Department of Health Professions.
Department of Historic Resources.
Department of Housing and Community Development.
Department of Information Technology.
Department of Juvenile Justice.
Department of Labor and Industry.
Department of Law.
Department of Medical Assistance Services.
Department of Mental Health, Mental Retardation and Substance Abuse Services.

Department of Military Affairs.
Department of Mines, Minerals and Energy.
Department of Minority Business Enterprise.
Department of Motor Vehicles.
Department of Personnel and Training.
Department of Planning and Budget.
Department of Professional and Occupational Regulation.
Department of Rail and Public Transportation.
Department of Rehabilitative Services.
~~Department for Rights of Virginians with Disabilities.~~
Department of Social Services.
Department of State Police.
Department of Taxation.
Department of Technology Planning.
Department of Transportation.
Department of the Treasury.
Department of Veterans' Affairs.
Department for the Visually Handicapped.
Governor's Employment and Training Department.

§ 2.1-1.3. Entities subject to standard nomenclature.

The following independent administrative entities are subject to the standard nomenclature provisions of § 2.1-1.2:

Chesapeake Bay Local Assistance Department.
Department of Accounts.
Department for the Aging.
Department of Agriculture and Consumer Services.
Department of Alcoholic Beverage Control.
Department of Aviation.
Department of Business Assistance.
Department of Conservation and Recreation.
Department of Correctional Education.
Department of Corrections.
Department of Criminal Justice Services.
Department for the Deaf and Hard-of-Hearing.
Department of Education.
Department of Emergency Services.
Department of Environmental Quality.
Department of Employee Relations Counselors.
Department of Fire Programs.
Department of Forestry.
Department of Game and Inland Fisheries.
Department of General Services.
Department of Health.
Department of Health Professions.
Department of Historic Resources.
Department of Housing and Community Development.
Department of Information Technology.
Department of Juvenile Justice.
Department of Labor and Industry.
Department of Medical Assistance Services.
Department of Mental Health, Mental Retardation and Substance Abuse Services.
Department of Military Affairs.
Department of Mines, Minerals and Energy.
Department of Minority Business Enterprise.

Department of Motor Vehicles.
Department of Personnel and Training.
Department of Planning and Budget.
Department of Professional and Occupational Regulation.
Department of Rail and Public Transportation.
Department of Rehabilitative Services.
~~Department for Rights of Virginians with Disabilities.~~
Department of Social Services.
Department of State Police.
Department of Taxation.
Department of Technology Planning.
Department of Transportation.
Department of the Treasury.
Department of Veterans' Affairs.
Department for the Visually Handicapped.
Governor's Employment and Training Department.

§ 2.1-1.5. Entities not subject to standard nomenclature.

The following entities are not subject to the provisions of § 2.1-1.2 due to the unique characteristics or the enabling legislation of the entities:

Authorities

Assistive Technology Loan Fund Authority.
Medical College of Virginia Hospitals Authority.
Richmond Eye and Ear Hospital Authority.
Small Business Financing Authority.
Virginia Agriculture Development Authority.
Virginia College Building Authority.
Virginia Economic Development Partnership.
Virginia Housing Development Authority.
Virginia Information Providers Network Authority.
Virginia Innovative Technology Authority.
Virginia Port Authority.
Virginia Public Building Authority.
Virginia Public School Authority.
Virginia Resources Authority.

Boards

Board of Commissioners, Virginia Agriculture Development Authority.
Board of Commissioners, Virginia Port Authority.
Board of Directors, Assistive Technology Loan Fund Authority.
Board of Directors, Medical College of Virginia Hospitals Authority.
Board of Directors, Richmond Eye and Ear Hospital Authority.
Board of Directors, Small Business Financing Authority.
Board of Directors, Virginia Economic Development Partnership.
Board of Directors, Virginia Innovative Technology Authority.
Board of Directors, Virginia Resources Authority.
Board of Regents, Gunston Hall Plantation.
Board of Regents, James Monroe Memorial Law Office and Library.
Board of Trustees, Family and Children's Trust Fund.
Board of Trustees, Frontier Culture Museum of Virginia.
Board of Trustees, Jamestown-Yorktown Foundation.
Board of Trustees, Miller School of Albemarle.
Board of Trustees, Rural Virginia Development Foundation.
Board of Trustees, The Science Museum of Virginia.
Board of Trustees, Virginia Museum of Fine Arts.
Board of Trustees, Virginia Museum of Natural History.

Board of Trustees, Virginia Outdoor Foundation.
Board of Visitors, Christopher Newport University.
Board of Visitors, George Mason University.
Board of Visitors, Gunston Hall Plantation.
Board of Visitors, James Madison University.
Board of Visitors, Longwood College.
Board of Visitors, Mary Washington College.
Board of Visitors, Norfolk State University.
Board of Visitors, Old Dominion University.
Board of Visitors, Radford University.
Board of Visitors, The College of William and Mary in Virginia.
Board of Visitors to Mount Vernon.
Board of Visitors, University of Virginia.
Board of Visitors, Virginia Commonwealth University.
Board of Visitors, Virginia Military Institute.
Board of Visitors, Virginia Polytechnic Institute and State University.
Board of Visitors, Virginia State University.
Commonwealth Health Research Board.
Governing Board, Virginia College Building Authority.
Governing Board, Virginia Public School Authority.
Library Board, The Library of Virginia.
Motor Vehicle Dealer Board.
State Board for Community Colleges, Virginia Community College System.
Virginia-Israel Advisory Board.
(Effective until July 1, 2002) Wireless E-911 Service Board.

Commissions

Advisory Commission on the Virginia Schools for the Deaf and the Blind.
Alexandria Historical Restoration and Preservation Commission.
Charitable Gaming Commission.
Chesapeake Bay Bridge and Tunnel Commission.
Hampton Roads Sanitation District Commission.
Tobacco Indemnification and Community Revitalization Commission.

Districts

Chesapeake Bay Bridge and Tunnel District.
Hampton Roads Sanitation District.

Educational Institutions

Christopher Newport University.
Frontier Culture Museum of Virginia.
George Mason University.
James Madison University.
Jamestown-Yorktown Foundation.
Longwood College.
Mary Washington College.
Miller School of Albemarle.
Norfolk State University.
Old Dominion University.
Radford University.
The College of William and Mary in Virginia.
The Library of Virginia.
The Science Museum of Virginia.
University of Virginia.
Virginia Commonwealth University.
Virginia Community College System.
Virginia Military Institute.

Virginia Museum of Fine Arts.
Virginia Polytechnic Institute and State University.
Virginia State University.

Foundations

Chippokes Plantation Farm Foundation.
Rural Virginia Development Foundation.
Virginia Arts Foundation.
Virginia Land Conservation Foundation.
Virginia Historic Preservation Foundation.
Virginia Outdoor Foundation.
Virginia Tobacco Settlement Foundation.

Museum

Virginia Museum of Natural History.

Office

Virginia Office for Protection and Advocacy.

Partnership

A. L. Philpott Manufacturing Extension Partnership.

Plantation

Gunston Hall Plantation.

§ 2.1-1.5. Entities not subject to standard nomenclature.

The following entities are not subject to the provisions of § 2.1-1.2 due to the unique characteristics or the enabling legislation of the entities:

Authorities

Assistive Technology Loan Fund Authority.
Medical College of Virginia Hospitals Authority.
Richmond Eye and Ear Hospital Authority.
Small Business Financing Authority.
Virginia Agriculture Development Authority.
Virginia College Building Authority.
Virginia Economic Development Partnership.
Virginia Housing Development Authority.
Virginia Information Providers Network Authority.
Virginia Innovative Technology Authority.
Virginia Port Authority.
Virginia Public Building Authority.
Virginia Public School Authority.
Virginia Resources Authority.

Boards

Board of Commissioners, Virginia Agriculture Development Authority.
Board of Commissioners, Virginia Port Authority.
Board of Directors, Assistive Technology Loan Fund Authority.
Board of Directors, Medical College of Virginia Hospitals Authority.
Board of Directors, Richmond Eye and Ear Hospital Authority.
Board of Directors, Small Business Financing Authority.
Board of Directors, Virginia Economic Development Partnership.
Board of Directors, Virginia Innovative Technology Authority.
Board of Directors, Virginia Resources Authority.
Board of Regents, Gunston Hall Plantation.
Board of Regents, James Monroe Memorial Law Office and Library.
Board of Trustees, Family and Children's Trust Fund.
Board of Trustees, Frontier Culture Museum of Virginia.
Board of Trustees, Jamestown-Yorktown Foundation.
Board of Trustees, Miller School of Albemarle.
Board of Trustees, Rural Virginia Development Foundation.

Board of Trustees, The Science Museum of Virginia.
Board of Trustees, Virginia Museum of Fine Arts.
Board of Trustees, Virginia Museum of Natural History.
Board of Trustees, Virginia Outdoor Foundation.
Board of Visitors, Christopher Newport University.
Board of Visitors, The College of William and Mary in Virginia.
Board of Visitors, George Mason University.
Board of Visitors, Gunston Hall Plantation.
Board of Visitors, James Madison University.
Board of Visitors, Longwood College.
Board of Visitors, Mary Washington College.
Board of Visitors to Mount Vernon.
Board of Visitors, Norfolk State University.
Board of Visitors, Old Dominion University.
Board of Visitors, Radford University.
Board of Visitors, University of Virginia.
Board of Visitors, Virginia Commonwealth University.
Board of Visitors, Virginia Military Institute.
Board of Visitors, Virginia Polytechnic Institute and State University.
Board of Visitors, Virginia State University.
Commonwealth Health Research Board.
Governing Board, Virginia College Building Authority.
Governing Board, Virginia Public School Authority.
Library Board, The Library of Virginia.
Motor Vehicle Dealer Board.
State Board for Community Colleges, Virginia Community College System.
Virginia-Israel Advisory Board.
(Effective until July 1, 2002) Wireless E-911 Service Board.

Commissions

Advisory Commission on the Virginia Schools for the Deaf and the Blind.
Alexandria Historical Restoration and Preservation Commission.
Charitable Gaming Commission.
Chesapeake Bay Bridge and Tunnel Commission.
Hampton Roads Sanitation District Commission.

Districts

Chesapeake Bay Bridge and Tunnel District.
Hampton Roads Sanitation District.

Educational Institutions

Christopher Newport University.
Frontier Culture Museum of Virginia.
George Mason University.
James Madison University.
Jamestown-Yorktown Foundation.
Longwood College.
Mary Washington College.
Miller School of Albemarle.
Norfolk State University.
Old Dominion University.
Radford University.
The College of William and Mary in Virginia.
The Library of Virginia.
The Science Museum of Virginia.
University of Virginia.
Virginia Commonwealth University.

Virginia Community College System.
Virginia Military Institute.
Virginia Museum of Fine Arts.
Virginia Polytechnic Institute and State University.
Virginia State University.

Foundations

Chippokes Plantation Farm Foundation.
Rural Virginia Development Foundation.
Virginia Arts Foundation.
Virginia Conservation and Recreation Foundation.
Virginia Outdoor Foundation.

Museum

Virginia Museum of Natural History.

Office

Virginia Office for Protection and Advocacy.

Partnership

A. L. Philpott Manufacturing Extension Partnership.

Plantation

Gunston Hall Plantation.

§ 2.1-51.15. Agencies for which responsible.

The Secretary of Health and Human Resources shall be responsible to the Governor for the following agencies: Department of Health, Department for the Visually Handicapped, Department of Health Professions, Department for the Aging, Department of Mental Health, Mental Retardation and Substance Abuse Services, Department of Rehabilitative Services, Department of Social Services, ~~Department for Rights of Virginians with Disabilities,~~ Department of Medical Assistance Services, the Council on Indians, Governor's Employment and Training Department, Child Day-Care Council, Virginia Department for the Deaf and Hard-of-Hearing, and the Virginia Council on Coordinating Prevention. The Governor may, by executive order, assign any other state executive agency to the Secretary of Health and Human Resources, or reassign any agency listed above to another secretary.

§ 2.1-116. Certain officers and employees exempt from chapter.

The provisions of this chapter shall not apply to:

1. Officers and employees for whom the Constitution specifically directs the manner of selection;

2. Officers and employees of the Supreme Court and the Court of Appeals;

3. Officers appointed by the Governor, whether confirmation by the General Assembly or by either house thereof is required or not;

4. Officers elected by popular vote or by the General Assembly or either house thereof;

5. Members of boards and commissions however selected;

6. Judges, referees, receivers, arbiters, masters and commissioners in chancery, commissioners of accounts, and any other persons appointed by any court to exercise judicial functions, and jurors and notaries public;

7. Officers and employees of the General Assembly and persons employed to conduct temporary or special inquiries, investigations, or examinations on its behalf;

8. The presidents, and teaching and research staffs of state educational institutions;

9. Commissioned officers and enlisted personnel of the national guard and the naval militia;

10. Student employees in institutions of learning, and patient or inmate help in other state institutions;

11. Upon general or special authorization of the Governor, laborers, temporary employees and employees compensated on an hourly or daily basis;

12. County, city, town and district officers, deputies, assistants and employees;

13. The employees of the Virginia Workers' Compensation Commission;

14. The officers and employees of the Virginia Retirement System;

15. Employees whose positions are identified by the State Council of Higher Education and the boards of the Virginia Museum of Fine Arts, the Science Museum of Virginia, the Jamestown-Yorktown Foundation, the Frontier Culture Museum of Virginia, the Virginia Museum of

Natural History and The Library of Virginia, and approved by the Director of the Department of Personnel and Training as requiring specialized and professional training;

16. Employees of the State Lottery Department;

17. Production workers for the Virginia Industries for the Blind Sheltered Workshop programs;

18. [Repealed.]

19. Employees of the Medical College of Virginia Hospitals Authority;

20. Employees of the University of Virginia Medical Center. Any changes in compensation plans for such employees shall be subject to the review and approval of the Board of Visitors of the University of Virginia. The University of Virginia shall ensure that its procedures for hiring University of Virginia Medical Center personnel are based on merit and fitness. Such employees shall remain subject to the provisions of Chapter 10.01 (§ 2.1-116.01 et seq.) of Title 2.1;

21. In executive branch agencies the employee who has accepted serving in the capacity of chief deputy, or equivalent, and the employee who has accepted serving in the capacity of a confidential assistant for policy or administration. An employee serving in either one of these two positions shall be deemed to serve on an employment-at-will basis. An agency may not exceed two employees who serve in this exempt capacity;

22. Employees of Virginia Correctional Enterprises. Such employees shall remain subject to the provisions of Chapter 10.01 (§ 2.1-116.01 et seq.) of Title 2.1;

23. Officers and employees of the Virginia Port Authority;

24. Employees of the Virginia Higher Education Tuition Trust Fund; ~~and~~

25. Directors of state facilities operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services employed or reemployed by the Commissioner after July 1, 1999, under a contract pursuant to § 37.1-42.2*; and*

26. The Director of the Virginia Office for Protection and Advocacy.

§ 2.1-122. Employment of special counsel generally.

No special counsel shall be employed for or by the Governor or any state department, institution, division, commission, board, bureau, agency, entity, official, justice of the Supreme Court, or judge of any circuit court or district court except in the following cases:

~~(a)~~ *1.* Where because of the nature of the service to be performed, the Attorney General's office is unable to render same, the Governor after issuing an exemption order stating with particularity the facts and reasons upon which he bases his conclusion that the Attorney General's office is unable to render such service, may employ special counsel to render such service as the Governor may deem necessary and proper.

~~(b)~~ *2.* In cases of legal services in civil matters to be performed for the Commonwealth, where it is impracticable or uneconomical for the Attorney General to render same, he may employ special counsel whose compensation shall be paid out of the appropriation for the Attorney General's office.

~~(c)~~ *3.* In cases of legal services in civil matters to be performed for any state department, institution, division, commission, board, bureau, agency, entity, official, justice of the Supreme Court, or judge of any circuit court or district court where it is impracticable or uneconomical for the Attorney General's office to render same, special counsel may be employed but only upon the written recommendation of the Attorney General, who shall approve all requisitions drawn upon the Comptroller for warrants as compensation for such special counsel before the Comptroller shall have authority to issue such warrants.

~~(d)~~ *4.* In cases where the Attorney General certifies to the Governor that it would be improper for the Attorney General's office to render legal services due to a conflict of interests, or that he is unable to render certain legal services, the Governor may employ special counsel or other assistance to render such services as may be necessary.

5. In cases of legal services in civil matters to be performed by the Virginia Office for Protection and Advocacy pursuant to Chapter 8.1 (§ 51.5-39.1 et seq.) of Title 51.5.

§ 2.1-373.13. Public Guardian and Conservator Advisory Board created; duties; membership; terms.

There is hereby created the Public Guardian and Conservator Advisory Board (the "Board") which shall report to and advise the Commissioner on the means for effectuating the purposes of this article and shall assist in the coordination and management of the local and regional programs appointed to act as public guardians and conservators pursuant to Chapter 4 (§ 37.1-128.01 et seq.) of Title 37.1.

The Board shall provide advice and counsel on the provision of high quality guardianship service and avoidance of conflicts of interest, promote the mobilization of activities and resources of public and private sector entities to effectuate the purposes of this article, and make recommendations regarding appropriate legislative and executive actions, including, but not limited to, recommendations governing alternatives for local programs to follow upon repeal of the authority granted to the courts pursuant to § 37.1-134.19 to appoint the sheriff as guardian or conservator when the maximum staff to client ratio of the local program is met or exceeded.

The Board shall consist of no more than fifteen members who shall be appointed by the Governor as follows: one representative of the Virginia Guardianship Association; one representative of the Virginia Area Agencies on Aging, one representative of the Virginia State Bar, one active or retired circuit court judge upon recommendation of the Chief Justice of the Supreme Court, one representative of the Association of Retarded Citizens, one representative of the Virginia Alliance for the Mentally Ill, one representative of the Virginia League of Social Service Executives, one representative of the Association of Community Service Boards, the Commissioner of the Department of Social Services or his designee, the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services or his designee, the Director of the Virginia ~~Department for the Rights of Virginians with Disabilities~~ *Office for Protection and Advocacy* or his designee, and one person who is a member of the Governor's Advisory Board for the Department for the Aging and such other individuals who may be qualified to assist in the duties of the Board.

The Commissioners of the Departments of Social Services and Mental Health, Mental Retardation and Substance Abuse Services or their designees, the Director of the Virginia ~~Department for Rights of Virginians with Disabilities~~ *Office for Protection and Advocacy* or his designee, and the representative of the Board for the Department for the Aging, shall serve terms coincident with their terms of office or in the case of designees, the term of the Commissioner or Director. Of the other members of the Board, five of the appointees shall serve for four-year terms and the remainder shall serve for three-year terms. No member shall serve more than two successive terms. A vacancy occurring other than by expiration of term shall be filled for the unexpired term. Each year, the Board shall elect a chairman and a vice-chairman from among its members. Five members of the Board shall constitute a quorum. Members shall receive no compensation for their services but shall be reimbursed for all reasonable and necessary expenses incurred in the discharge of their duties as members of the Board.

§ 2.1-703.1. Interagency Coordinating Council on Housing for the Disabled.

There shall be an Interagency Coordinating Council on Housing for the Disabled, hereinafter referred to as "Council." The Council shall consist of one representative, to be appointed by the agency executive, from each of the following: Department of Professional and Occupational Regulation, Department of Housing and Community Development, Virginia Housing Development Authority, ~~Department for Rights of Virginians with Disabilities~~ *Virginia Office for Protection and Advocacy*, Department for the Aging, Department for the Deaf and Hard-of-Hearing, Department of Mental Health, Mental Retardation and Substance Abuse Services, Department of Rehabilitative Services, Department of Social Services and Department for the Visually Handicapped. The Secretary of Commerce and Trade and Secretary of Health and Human Resources shall serve ex officio on the Council. The appropriate agency executive may appoint additional members as required. The Council shall annually elect a chairman. Each agency shall contribute a pro rata share of the required support services.

The Council shall provide and promote cross-secretariat interagency leadership for comprehensive planning and coordinated implementation of proposals to increase and maximize use of existing low-income housing for the disabled and to ensure development of accompanying community support services. The Council shall stimulate action by government agencies and enlist the cooperation of the nonprofit and private sectors. The Council shall develop a state policy on housing for the disabled for submission to the Governor. The policy shall be reviewed and updated as necessary. The Council shall submit to the Governor and various agency executives a report and recommendations at least annually.

§ 2.1-762. Early intervention agencies committee.

An early intervention agencies committee shall be established to ensure the implementation of a

comprehensive system for early intervention services. The committee shall be composed of the Commissioner of the Department of Health, the Director of the Department for the Deaf and Hard-of-Hearing, the Superintendent of Public Instruction, the Director of the Department of Medical Assistance Services, the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services, the Commissioner of the Department of Social Services, the Commissioner of the Department for the Visually Handicapped, the Director of the ~~Department for Rights of Virginians with Disabilities~~ *Virginia Office for Protection and Advocacy*, and the Commissioner of the Bureau of Insurance within the State Corporation Commission. The committee shall meet at least twice each fiscal year and shall make annual recommendations to the Secretary of Health and Human Resources and the Secretary of Education on issues that require interagency planning, financing, and resolution. Each member of the committee shall appoint a representative from his agency to serve on the Virginia Interagency Coordinating Council.

§ 9-271. Comprehensive Prevention Plan.

A Comprehensive Prevention Plan shall be jointly developed biennially by the following agencies: Department for the Aging, Department of Alcoholic Beverage Control, Department of Correctional Education, Department of Corrections, Department of Juvenile Justice, Department of Criminal Justice Services, Department of Education, Department of Health, Department of Medical Assistance Services, Department of Mental Health, Mental Retardation and Substance Abuse Services, Department of Motor Vehicles, ~~Department for Rights of Virginians with Disabilities~~ *Virginia Office for Protection and Advocacy*, and Department of Social Services. The Secretary of Health and Human Resources shall designate an agency to coordinate development of the Plan. The Comprehensive Prevention Plan shall coordinate and integrate the planning efforts of the state agencies listed above and the private sector in order to provide a broad prevention agenda for the Commonwealth, enable communities to design and implement prevention programs that meet the identified needs of the community and facilitate the development of interagency and broad-based community involvement in the development of prevention programs. The Comprehensive Prevention Plan shall identify priority prevention issues and challenges, prevention goals and objectives and public and private strategies to achieve goals and objectives. For the purposes of the Plan, prevention activities, issues and programs shall be those activities which promote the objective identified in subsection B of § 9-270. The Plan with a cost analysis of the proposed strategies shall be submitted to the House Committee on Health, Welfare and Institutions and the Senate Committees on Rehabilitation and Social Services and Education and Health for the purpose of analysis, review and comment prior to implementation.

§ 9-323. Specialized Transportation Technical Advisory Committee.

A Specialized Transportation Technical Advisory Committee shall assist the Council. The Committee shall be composed of representatives from the following agencies: the Department for the Aging, the Department for the Deaf and Hard-of-Hearing, the Department of Education, the Department of Medical Assistance Services, the Department of Mental Health, Mental Retardation and Substance Abuse Services, the ~~Department for Rights of Virginians with Disabilities~~ *Virginia Office for Protection and Advocacy*, the Department of Rehabilitative Services, the Department of Social Services, the Department of Transportation's Directorate of Rail and Public Transportation or its successor agency and the Department for the Visually Handicapped and three representatives of public transportation providers or transportation district commissions to be appointed by the Council.

§ 51.5-1. Declaration of policy.

It is the policy of this Commonwealth to encourage and enable persons with disabilities to participate fully and equally in the social and economic life of the Commonwealth and to engage in remunerative employment. To these ends, the General Assembly directs the Governor, ~~Department for Rights of Virginians with Disabilities~~ *Virginia Office for Protection and Advocacy*, Department for the Aging, Department for the Deaf and Hard-of-Hearing, Department of Education, Department of Health, Department of Housing and Community Development, Department of Mental Health, Mental Retardation and Substance Abuse Services, ~~Board for Rights of Virginians with Disabilities~~ *Virginia Board for People with Disabilities*, Department of Rehabilitative Services, Department of Social Services, Department for the Visually Handicapped, and such other agencies as the Governor deems appropriate, to provide, in a comprehensive and coordinated manner which makes the best use of available resources, those services necessary to assure equal opportunity to persons with disabilities in

the Commonwealth.

The provisions of this title shall be known and may be cited as "The Virginians ~~With~~ *with* Disabilities Act."

§ 51.5-2. Plan of cooperation.

The ~~Department for Rights of Virginians with Disabilities~~ *Virginia Office for Protection and Advocacy*, Department for the Aging, Department for the Deaf and Hard-of-Hearing, Department of Education, Department of Health, Department of Housing and Community Development, Department of Mental Health, Mental Retardation and Substance Abuse Services, Department of Rehabilitative Services, Department of Social Services, Department for the Visually Handicapped and such other agencies as are designated by the Governor which serve persons with disabilities shall formulate a plan of cooperation in accordance with the provisions of this title and the federal Rehabilitation Act. The goal of this plan shall be to promote the fair and efficient provision of rehabilitative and other services to persons with disabilities and to protect the rights of persons with disabilities.

The plan of cooperation shall include an annual update of budgetary commitment under the plan, specifying how many persons with disabilities, by type of impairment, will be served under the plan. The plan of cooperation shall include consideration of first pay provisions for entitlement programs of a cooperating agency. If entitlement services are part of a client's individualized written rehabilitation program or equivalent plan for services, funds shall be paid from the entitlement program when possible. The plan and budgetary commitments shall be reviewed by the respective boards of the cooperating agencies, reviewed by the Virginia Board for People with Disabilities and submitted for approval to the appropriate secretaries within the Governor's Office before implementation.

CHAPTER 8.1.

PROTECTION AND ADVOCACY SERVICES.

§ 51.5-39.1. Definitions.

As used in this chapter, unless the context requires a different meaning:

"Abuse" means any act or failure to act by an employee of a facility or program rendering care or treatment to individuals with mental, cognitive, sensory, physical or other disabilities that was performed or was failed to be performed knowingly, recklessly, or intentionally, and that caused or might have caused physical or psychological harm, injury, or death to a person receiving care or treatment for mental, cognitive, sensory, physical or other disabilities. Examples of abuse include, but are not limited to, acts such as:

1. Rape, sexual assault, or other criminal sexual behavior;

2. Assault or battery;

3. Use of language that demeans, threatens, intimidates or humiliates the person;

4. Misuse or misappropriation of the person's assets, goods, or property;

5. Use of excessive force when placing a person in physical or mechanical restraint;

6. Use of physical or mechanical restraints on a person that is not in compliance with federal and state laws, regulations, and policies, professionally accepted standards of practice or the person's individualized services plan; and

7. Use of more restrictive or intensive services or denial of services to punish the person or that is not consistent with his individualized services plan.

"Board" means the Board for Protection and Advocacy.

"Disabilities" means mental, cognitive, sensory, physical, or other disabilities covered by the federal Protection and Advocacy for Individuals with Mental Illness Act, the federal Developmental Disabilities Assistance and Bill of Rights Act, the federal Rehabilitation Act of 1973, as amended, and such other related federal and state programs as may be established by federal and state law.

"Neglect" means failure by an individual, program or facility responsible for providing services to provide nourishment, treatment, care, goods, or services necessary to the health, safety or welfare of a person receiving care or treatment for mental, cognitive, sensory, physical or other disabilities.

"Office" means the Virginia Office for Protection and Advocacy.

§ 51.5-39.2. The Virginia Office for Protection and Advocacy established; governing board; terms.

A. The Department for Rights of Virginians with Disabilities is hereby reestablished as an independent state agency, the Virginia Office for Protection and Advocacy. The Office is designated as the agency to protect and advocate for the rights of persons with mental, cognitive, sensory,

physical or other disabilities and to receive federal funds on behalf of the Commonwealth of Virginia to implement the federal Protection and Advocacy for Individuals with Mental Illness Act, the federal Developmental Disabilities Assistance and Bill of Rights Act, the federal Rehabilitation Act, the Virginians with Disabilities Act and such other related programs as may be established by state and federal law. Notwithstanding any other provision of law, the Office shall be independent of the Office of the Attorney General and shall have the authority, pursuant to subdivision 5 of § 2.1-122, to employ and contract with legal counsel to carry out the purposes of this chapter and to employ and contract with legal counsel to advise and represent the Office, to initiate actions on behalf of the Office, and to defend the Office and its officers, agents and employees in the course and scope of their employment or authorization, in any matter, including state, federal and administrative proceedings. Compensation for legal counsel shall be paid out of the funds appropriated for the administration of the Office. However, in the event defense is provided under Article 5.1 (§ 2.1-526.1 et seq.) of Chapter 32 of Title 2.1, counsel shall be appointed pursuant to subdivision 4 of § 2.1-122. The Office shall provide ombudsman, advocacy and legal services to persons with disabilities who may be represented by the Office. The Office is authorized to receive and act upon complaints concerning discrimination on the basis of disability, abuse and neglect or other denial of rights, and practices and conditions in institutions, hospitals, and programs for persons with disabilities, and to investigate complaints relating to abuse and neglect or other violation of the rights of persons with disabilities in proceedings under state or federal law, and to initiate any proceedings to secure the rights of such persons.

B. The Office shall be governed by an eleven-member board. The Board shall be composed of members who broadly represent or are knowledgeable about the needs of persons with disabilities served by the Office. Two or more members shall have experience in the fields of developmental disabilities and mental health. Persons with mental, cognitive, sensory or physical disabilities or family members, guardians, advocates, or authorized representatives of such persons shall be included. No elected official shall serve on the Board. No current employee of the Departments of Mental Health, Mental Retardation and Substance Abuse Services, Social Services, Health, Rehabilitative Services or for the Visually Handicapped or a community services board, behavioral health authority, or local government department with a policy-advisory community services board shall serve as a member. In appointing the members of the Board, consideration shall be given to persons nominated by statewide groups that advocate for the physically, developmentally and mentally disabled. The Governor and General Assembly shall not be limited in their appointments to persons so nominated; however, the Governor and General Assembly shall seriously consider the persons nominated and appoint such persons whenever feasible.

C. The Governor shall appoint three members of the Board who shall be confirmed by the affirmative vote of a majority of those voting in each house of the General Assembly. The Speaker of the House of Delegates shall appoint four members, and the Senate Committee on Privileges and Elections shall appoint four members of the Board. The Board appointments shall be made to give representation insofar as feasible to various geographic areas of the Commonwealth.

D. The terms of initial members of the Board shall be as follows:

1. Two legislative appointees shall be appointed for a term of one year each;

2. One gubernatorial and two legislative appointees shall be appointed for a term of two years each;

3. One gubernatorial and two legislative appointees shall be appointed for a term of three years each; and

4. One gubernatorial and two legislative appointees shall be appointed for a term of four years each.

Thereafter, members shall be appointed for four-year terms.

E. Appointments to fill vacancies shall be for the unexpired terms. A vacancy of a legislatively appointed member shall be filled by either the Speaker of the House of Delegates or the Senate Committee on Privileges and Elections, and any such appointee shall enter upon and continue in office, subject to confirmation at the next session of the General Assembly. If the General Assembly fails to confirm his appointment, such person shall not be eligible for reappointment. Members shall continue to serve until such time as their successors have been appointed and duly qualified to serve.

F. A member who has been appointed to a four-year term shall not be eligible for reappointment during the two-year period beginning on the date on which such four-year term expired. However, upon the expiration of an appointment to an unexpired term, or an appointment described in subdivision D 1, 2, or 3 of this section, a member may be reappointed to a four-year term.

G. The Board shall elect a chairman and a vice-chairman from its members and appoint a secretary who may or may not be a member of the Board. A majority of the members of the Board shall constitute a quorum. The chairman shall preside over meetings of the Board and perform additional duties as may be set by resolution of the Board.

H. The Board shall meet at least four times each year. Members shall be reimbursed for their necessary and actual expenses incurred in the performance of their official duties.

I. Members of the Board shall be subject to removal from office only as set forth in Article 7 (§ 24.2-230 et seq.) of Chapter 2 of Title 24.2. The Circuit Court of the City of Richmond shall have exclusive jurisdiction over all proceedings for such removal.

§ 51.5-39.3. Application of State and Local Government Conflict of Interests Act.

The provisions of the State and Local Government Conflict of Interests Act (§ 2.1-639.1 et seq.) shall apply to the members of the Board and employees of the Office.

§ 51.5-39.4. Powers and duties of the Office.

The Office shall have the following powers and duties:

1. To monitor the implementation of Chapter 9 (§ 51.5-40 et seq.) of this title and to render assistance to persons with disabilities in the protection of their rights under the laws of the Commonwealth and of the United States.

2. To exhaust in a timely manner all appropriate administrative remedies to resolve complaints concerning violations of rights of persons with disabilities, when those rights are related to such disabilities. When such procedures fail or if, in pursuing administrative remedies, the Office determines that any matter with respect to an individual with a disability will not be resolved in a reasonable time, the Office shall have the authority to pursue legal and other alternative remedies to protect the rights of such persons.

3. To access during normal business hours and at other reasonable times all records relating to expenditures of state and federal funds or to the admission, care, treatment, habilitation, or provision of other services to individuals with disabilities, that are maintained by any state or local government department or agency, contractors of those departments or agencies, and any other entity or person providing services to a person with disabilities who may be represented by the Office, where such records relate to any complaint or investigation received by the Office. When such records contain personal identifying information about the person or persons, such information shall not be released nor shall the Office have access to it unless he or they, or his or their designated representative, consents to such release or access. However, there shall be no right of access to privileged communications pursuant to § 8.01-581.17.

4. To access any records maintained in computerized data banks of the state and local government departments or agencies, contractors of those departments or agencies, or any other entities or persons that provide services to a person who may be represented by the Office. When such records contain personal identifying information about the person or persons, such information shall not be released nor shall the Office have access to it unless he or they, or his or their designated representative, consents to such release or access. However, there shall be no right of access to privileged communications pursuant to § 8.01-581.17.

5. To access, during normal working hours, personnel of the state or local government departments or agencies, contractors of those departments or agencies, and other service-providing entities or persons providing services to a person with disabilities who may be represented by the Office.

6. To access, at any time, all persons with disabilities detained, hospitalized, institutionalized, or receiving services or who may be represented by the Office.

7. To monitor compliance with the human rights regulations promulgated pursuant to Article 3 (§ 37.1-84.1 et seq.) of Chapter 2 of Title 37.1.

§ 51.5-39.5. Powers and duties of the Board; Protection and Advocacy Fund.

A. The Virginia Office for Protection and Advocacy shall be administered by the Board, whose

powers and duties include but are not limited to:

1. Appointing and annually evaluating the performance of a director, who shall not be a member of the Board, to serve as the chief executive officer of the Virginia Office for Protection and Advocacy at the pleasure of the Board. The Director shall be a person qualified by knowledge, skills, and abilities to administer and direct the provision of protection and advocacy services regarding the rights of persons with disabilities.

2. Preparing and submitting a budget to the General Assembly for the operation of the Office and the Board.

3. Establishing general policies for the Office and advising and assisting the Director in developing annual program priorities.

4. Establishing annual program priorities of the Office.

5. Adopting regulations, policies and procedures and making determinations necessary to carry out the provisions of this chapter and Chapter 9 (§ 51.5-40 et seq.) of this title. The adoption of such regulations shall be consistent with the provisions of Article 2 (§ 9-6.14:7.1 et seq.) of the Administrative Process Act.

6. Monitoring and evaluating the operations of the Office.

7. Maintaining records of its proceedings and making such records available for inspection by the public.

8. Performing any other acts necessary to carry out the provisions of this chapter.

B. The Board shall have the authority to apply for and accept, gifts, donations, grants, and bequests on behalf of the Office from the United States government and agencies and instrumentalities thereof and from any other source and to deposit all moneys received in the Protection and Advocacy Fund created pursuant to this subsection. To these ends, the Board shall have the power to comply with such conditions and execute such agreements as may be necessary, convenient or desirable, consistent with policies, rules, and regulations of the Board.

There is hereby created in the state treasury a special nonreverting fund to be known as the Protection and Advocacy Fund, hereafter referred to as "the Fund," to be administered by the Board. The Fund shall consist of (i) gifts, donations, grants, and bequests on behalf of the Office from the United States government and agencies and instrumentalities thereof; (ii) such other funds as may be appropriated by the General Assembly from time to time and designated for this Fund; (iii) funds from any other source; and (iv) all interest, dividends and appreciation which may accrue thereto. Any moneys remaining in the Fund, including interest thereon, at the end of each fiscal year shall not revert to the general fund but shall remain in the Fund.

The total costs for the operation and administration of the Office shall be funded from the Fund and shall be in such amount as provided in the general appropriations act.

§ 51.5-39. 6. Powers and duties of Director.

The Director shall have the following powers and duties:

1. To supervise and manage the daily operations of the Office and to carry out such duties as provided in this section.

2. To employ such qualified staff, including ombudsmen, advocates and legal counsel, as shall be necessary for carrying out the purposes of this chapter and Chapter 9 (§ 51.5-40 et seq.) of this title. The Director shall appoint a legal director, subject to the approval of the Board, who shall be an attorney qualified by knowledge, skills and abilities to direct the provision of protection and advocacy legal services regarding the rights of persons with disabilities.

3. To make and enter into all contracts and agreements, subject to ratification by the Board, necessary or incidental to the performance of the Office's duties and the execution of its powers under this chapter, including but not limited to contracts with the United States, other states, and agencies and political subdivisions of the Commonwealth, consistent with policies, rules and regulations of the Board.

4. To advise and assist the Board in developing a budget.

5. To annually prepare a report of activities of the Board and Office and submit copies of the report to the Governor, the chairs of the Senate Committee on Education and Health, the House Committee on Health, Welfare and Institutions, and the House Appropriations and Senate Finance Committees and make the report available to the public.

F. A member who has been appointed to a four-year term shall not be eligible for reappointment during the two-year period beginning on the date on which such four-year term expired. However, upon the expiration of an appointment to an unexpired term, or an appointment described in subdivision D 1, 2, or 3 of this section, a member may be reappointed to a four-year term.

G. The Board shall elect a chairman and a vice-chairman from its members and appoint a secretary who may or may not be a member of the Board. A majority of the members of the Board shall constitute a quorum. The chairman shall preside over meetings of the Board and perform additional duties as may be set by resolution of the Board.

H. The Board shall meet at least four times each year. Members shall be reimbursed for their necessary and actual expenses incurred in the performance of their official duties.

I. Members of the Board shall be subject to removal from office only as set forth in Article 7 (§ 24.2-230 et seq.) of Chapter 2 of Title 24.2. The Circuit Court of the City of Richmond shall have exclusive jurisdiction over all proceedings for such removal.

§ 51.5-39.3. Application of State and Local Government Conflict of Interests Act.

The provisions of the State and Local Government Conflict of Interests Act (§ 2.1-639.1 et seq.) shall apply to the members of the Board and employees of the Office.

§ 51.5-39.4. Powers and duties of the Office.

The Office shall have the following powers and duties:

1. To monitor the implementation of Chapter 9 (§ 51.5-40 et seq.) of this title and to render assistance to persons with disabilities in the protection of their rights under the laws of the Commonwealth and of the United States.

2. To exhaust in a timely manner all appropriate administrative remedies to resolve complaints concerning violations of rights of persons with disabilities, when those rights are related to such disabilities. When such procedures fail or if, in pursuing administrative remedies, the Office determines that any matter with respect to an individual with a disability will not be resolved in a reasonable time, the Office shall have the authority to pursue legal and other alternative remedies to protect the rights of such persons.

3. To access during normal business hours and at other reasonable times all records relating to expenditures of state and federal funds or to the admission, care, treatment, habilitation, or provision of other services to individuals with disabilities, that are maintained by any state or local government department or agency, contractors of those departments or agencies, and any other entity or person providing services to a person with disabilities who may be represented by the Office, where such records relate to any complaint or investigation received by the Office. When such records contain personal identifying information about the person or persons, such information shall not be released nor shall the Office have access to it unless he or they, or his or their designated representative, consents to such release or access. However, there shall be no right of access to privileged communications pursuant to § 8.01-581.17.

4. To access any records maintained in computerized data banks of the state and local government departments or agencies, contractors of those departments or agencies, or any other entities or persons that provide services to a person who may be represented by the Office. When such records contain personal identifying information about the person or persons, such information shall not be released nor shall the Office have access to it unless he or they, or his or their designated representative, consents to such release or access. However, there shall be no right of access to privileged communications pursuant to § 8.01-581.17.

5. To access, during normal working hours, personnel of the state or local government departments or agencies, contractors of those departments or agencies, and other service-providing entities or persons providing services to a person with disabilities who may be represented by the Office.

6. To access, at any time, all persons with disabilities detained, hospitalized, institutionalized, or receiving services or who may be represented by the Office.

7. To monitor compliance with the human rights regulations promulgated pursuant to Article 3 (§ 37.1-84.1 et seq.) of Chapter 2 of Title 37.1.

§ 51.5-39.5. Powers and duties of the Board; Protection and Advocacy Fund.

A. The Virginia Office for Protection and Advocacy shall be administered by the Board, whose

powers and duties include but are not limited to:

1. Appointing and annually evaluating the performance of a director, who shall not be a member of the Board, to serve as the chief executive officer of the Virginia Office for Protection and Advocacy at the pleasure of the Board. The Director shall be a person qualified by knowledge, skills, and abilities to administer and direct the provision of protection and advocacy services regarding the rights of persons with disabilities.

2. Preparing and submitting a budget to the General Assembly for the operation of the Office and the Board.

3. Establishing general policies for the Office and advising and assisting the Director in developing annual program priorities.

4. Establishing annual program priorities of the Office.

5. Adopting regulations, policies and procedures and making determinations necessary to carry out the provisions of this chapter and Chapter 9 (§ 51.5-40 et seq.) of this title. The adoption of such regulations shall be consistent with the provisions of Article 2 (§ 9-6.14:7.1 et seq.) of the Administrative Process Act.

6. Monitoring and evaluating the operations of the Office.

7. Maintaining records of its proceedings and making such records available for inspection by the public.

8. Performing any other acts necessary to carry out the provisions of this chapter.

B. The Board shall have the authority to apply for and accept, gifts, donations, grants, and bequests on behalf of the Office from the United States government and agencies and instrumentalities thereof and from any other source and to deposit all moneys received in the Protection and Advocacy Fund created pursuant to this subsection. To these ends, the Board shall have the power to comply with such conditions and execute such agreements as may be necessary, convenient or desirable, consistent with policies, rules, and regulations of the Board.

There is hereby created in the state treasury a special nonreverting fund to be known as the Protection and Advocacy Fund, hereafter referred to as "the Fund," to be administered by the Board. The Fund shall consist of (i) gifts, donations, grants, and bequests on behalf of the Office from the United States government and agencies and instrumentalities thereof; (ii) such other funds as may be appropriated by the General Assembly from time to time and designated for this Fund; (iii) funds from any other source; and (iv) all interest, dividends and appreciation which may accrue thereto. Any moneys remaining in the Fund, including interest thereon, at the end of each fiscal year shall not revert to the general fund but shall remain in the Fund.

The total costs for the operation and administration of the Office shall be funded from the Fund and shall be in such amount as provided in the general appropriations act.

§ 51.5-39. 6. Powers and duties of Director.

The Director shall have the following powers and duties:

1. To supervise and manage the daily operations of the Office and to carry out such duties as provided in this section.

2. To employ such qualified staff, including ombudsmen, advocates and legal counsel, as shall be necessary for carrying out the purposes of this chapter and Chapter 9 (§ 51.5-40 et seq.) of this title. The Director shall appoint a legal director, subject to the approval of the Board, who shall be an attorney qualified by knowledge, skills and abilities to direct the provision of protection and advocacy legal services regarding the rights of persons with disabilities.

3. To make and enter into all contracts and agreements, subject to ratification by the Board, necessary or incidental to the performance of the Office's duties and the execution of its powers under this chapter, including but not limited to contracts with the United States, other states, and agencies and political subdivisions of the Commonwealth, consistent with policies, rules and regulations of the Board.

4. To advise and assist the Board in developing a budget.

5. To annually prepare a report of activities of the Board and Office and submit copies of the report to the Governor, the chairs of the Senate Committee on Education and Health, the House Committee on Health, Welfare and Institutions, and the House Appropriations and Senate Finance Committees and make the report available to the public.

6. To prepare reports, at the direction of the Board, on compliance with the human rights regulations promulgated pursuant to Article 3 (§ 37.1-84.1 et seq.) of Chapter 2 of Title 37.1 and make such reports available to the public.

7. To exercise such powers and perform such duties as are assigned to him by the Board.

§ 51.5-39.7. Ombudsman services for persons with disabilities.

A. There is hereby created within the Office an ombudsman section. The Director shall establish procedures for receiving complaints and conducting investigations for the purposes of resolving and mediating complaints regarding any activity, practice, policy, or procedure of any hospital, facility or program operated, funded or licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services, the Department of Rehabilitative Services, the Department of Social Services, or any other state or local agency, which is adversely affecting the health, safety, welfare, or civil or human rights of any person with mental, cognitive, sensory or physical disabilities. After initial investigation, the section may decline to accept any complaint it determines is frivolous or not made in good faith. The ombudsman section shall attempt to resolve the complaint at the lowest appropriate level, unless otherwise provided by law. The procedures shall require the section to:

1. Acknowledge the receipt of a complaint by sending written notice to the complainant within seven days after receiving the complaint.

2. When appropriate, provide written notice of a complaint to the Department of Mental Health, Mental Retardation and Substance Abuse Services or any other appropriate agency within seven days after receiving the complaint. The Department or agency receiving the complaint shall report its findings and actions no later than fourteen days after receiving the complaint.

3. Immediately refer a complaint made under this section to the Department of Mental Health, Mental Retardation and Substance Abuse Services or any other appropriate governmental agency whenever the complaint involves an immediate and substantial threat to the health or safety of a person with mental retardation, developmental disabilities, mental illness, or other disability. The Department or agency receiving the complaint shall report its findings and actions no later than forty-eight hours following its receipt of the complaint.

4. Within seven days after identifying a deficiency in the treatment of a person with a disability that is in violation of state or federal law or regulation, refer the matter in writing to the appropriate state agency. The state agency shall report on its findings and actions within seven days of receiving notice of the matter.

5. Advise the complainant and any person with a disability affected by the complaint, no more than thirty days after it receives the complaint, of any action it has taken and of any opinions and recommendations it has with respect to the complaint. The ombudsman section may request any party affected by the opinions or recommendations to notify the section, within a time period specified by the section, of any action the party has taken on its recommendations.

6. Any complaint not resolved through negotiation, mediation, or conciliation shall be referred by the ombudsman section to the Director or the Director's designee to determine whether further protection and advocacy services shall be provided by the Office.

B. The ombudsman section may make public any of its opinions or recommendations concerning a complaint, the responses of persons and governmental agencies to its opinions or recommendations, and any act, practice, policy, or procedure that adversely affects or may adversely affect the health, safety, welfare, or civil or human rights of a person with a disability, subject to the provisions of § 51.5-39.8.

C. The Office shall publicize its existence, functions, and activities, and the procedures for filing a complaint under this section, and send this information in written form to each provider of services to persons with disabilities, with instructions that the information is to be posted in a conspicuous place accessible to patients, residents, consumers, clients, visitors, and employees. The Office shall establish, maintain and publicize a toll-free number for receiving complaints.

§ 51.5-39.8. Confidentiality of records and communications of the Office.

A. All documentary and other evidence received or maintained by the Office or its agents in connection with specific complaints or investigations shall be confidential and not subject to the mandatory disclosure requirements of the Virginia Freedom of Information Act (§ 2.1-340 et seq.). However, access to one's own records shall not be denied unless otherwise prohibited by state or

federal law.

B. Communications between employees and agents of the Office and its clients or individuals requesting its services shall be privileged, as if between attorney and client.

C. Notwithstanding the provisions of this section, the Office shall be permitted to:

1. Issue a public report of the results of an investigation of a complaint which does not release the identity of any complainant or any person with mental illness, mental retardation, developmental disabilities or other disability, unless (i) such complainant or person or his legal representative consents in writing to such disclosure or (ii) such disclosure is required by court order.

2. Report the results of an investigation to responsible investigative or enforcement agencies should an investigation reveal information concerning any hospital, facility or other entity, its staff or employees, warranting possible sanctions or corrective action. This information may be reported to agencies responsible for licensing or accreditation, employee discipline, employee licensing or certification, or criminal prosecution.

§ 51.5-39.9. Cooperative agreements with state agencies regarding advocacy services for their clients.

Notwithstanding the foregoing, state agencies providing services to persons with disabilities may develop and maintain advocacy, client assistance or ombudsman services for their clients, which services may be within the agency and independent of the Office. The Office may enter into cooperative agreements with any state agency providing advocacy, client assistance, or ombudsman services for the agencies' clients, in order to ensure the protection of and advocacy for persons with disabilities, provided that such agreements do not restrict such authority as the Office may otherwise have to pursue any legal or administrative remedy on behalf of persons with disabilities.

§ 51.5-39.10. Immunity.

Any person who in good faith complains to the Office on behalf of a person with a disability, or who provides information or participates in the investigation of any such complaint, shall have immunity from any civil liability and shall not be subject to any penalties, sanctions, restrictions or retaliation as a consequence of making such complaint, providing such information or participating in such investigation.

§ 51.5-39.11. Employees of the Virginia Office for Protection and Advocacy.

Except as otherwise provided by law, the employees of the Virginia Office for Protection and Advocacy shall be subject to the provisions of the Virginia Personnel Act (§ 2.1-110 et seq.).

§ 51.5-40. Nondiscrimination under state grants and programs.

No otherwise qualified person with a disability shall, on the basis of disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving state financial assistance or under any program or activity conducted by or on behalf of any state agency. The ~~Department for Rights of Virginians with Disabilities~~ *Virginia Office for Protection and Advocacy* shall promulgate such regulations as may be necessary to implement this section. Such regulations shall be consistent, whenever applicable, with regulations imposed under the federal Rehabilitation Act of 1973, as amended, and the federal Americans with Disabilities Act of 1990.

§ 51.5-46. Remedies.

A. Any circuit court having chancery jurisdiction and venue pursuant to Title 8.01, on the petition of any person with a disability, shall have the right to enjoin the abridgement of rights set forth in this chapter and to order such affirmative equitable relief as is appropriate and to award compensatory damages and to award to a prevailing party reasonable attorneys' fees, except that a defendant shall not be entitled to an award of attorneys' fees unless the court finds that the claim was frivolous, unreasonable or groundless, or brought in bad faith. Compensatory damages shall not include damages for pain and suffering. Punitive or exemplary damages shall not be awarded.

B. An action may be commenced pursuant to this section any time within one year of the occurrence of any violation of rights under this chapter. However, such action shall be forever barred unless such claimant or his agent, attorney or representative has commenced such action or has filed by registered mail a written statement of the nature of the claim with the potential defendant or defendants within 180 days of the occurrence of the alleged violation. Any liability for back pay shall not accrue from a date more than 180 days prior to the filing of the notice or bill of complaint and

shall be limited to a total of 180 days, reduced by the amount of other earnings over the same period. The petitioner shall have a duty to mitigate damages.

C. The relief available for violations of this chapter shall be limited to the relief set forth in this section.

D. In any action in which the petitioner is represented by the ~~Department for the Rights of Virginians with Disabilities~~ *Virginia Office for Protection and Advocacy*, no attorneys' fees shall be awarded, nor shall the ~~Department for the Rights of Virginians with Disabilities~~ *Virginia Office for Protection and Advocacy* have the authority to institute any class action under this chapter.

§ 63.1-182.1. Rights and responsibilities of residents of adult care residences; certification of licensure.

A. Any resident of an adult care residence has the rights and responsibilities enumerated in this section. The operator or administrator of an adult care residence shall establish written policies and procedures to ensure that, at the minimum, each person who becomes a resident of the adult care residence:

1. Is fully informed, prior to or at the time of admission and during the resident's stay, of his rights and of all rules and expectations governing the resident's conduct, responsibilities, and the terms of the admission agreement; evidence of this shall be the resident's written acknowledgment of having been so informed, which shall be filed in his record;

2. Is fully informed, prior to or at the time of admission and during the resident's stay, of services available in the residence and of any related charges; this shall be reflected by the resident's signature on a current resident's agreement retained in the resident's file;

3. Unless a committee or conservator has been appointed, is free to manage his personal finances and funds regardless of source; is entitled to access to personal account statements reflecting financial transactions made on his behalf by the residence; and is given at least a quarterly accounting of financial transactions made on his behalf when a written delegation of responsibility to manage his financial affairs is made to the residence for any period of time in conformance with state law;

4. Is afforded confidential treatment of his personal affairs and records and may approve or refuse their release to any individual outside the residence except as otherwise provided in law and except in case of his transfer to another care-giving facility;

5. Is transferred or discharged only when provided with a statement of reasons, or for nonpayment for his stay, and is given reasonable advance notice; upon notice of discharge or upon giving reasonable advance notice of his desire to move, shall be afforded reasonable assistance to ensure an orderly transfer or discharge; such actions shall be documented in his record;

6. In the event a medical condition should arise while he is residing in the residence, is afforded the opportunity to participate in the planning of his program of care and medical treatment at the residence and the right to refuse treatment;

7. Is not required to perform services for the residence except as voluntarily contracted pursuant to a voluntary agreement for services which states the terms of consideration or remuneration and is documented in writing and retained in his record;

8. Is free to select health care services from reasonably available resources;

9. Is free to refuse to participate in human subject experimentation or to be party to research in which his identity may be ascertained;

10. Is free from mental, emotional, physical, sexual, and economic abuse or exploitation; is free from forced isolation, threats or other degrading or demeaning acts against him; and his known needs are not neglected or ignored by personnel of the residence;

11. Is treated with courtesy, respect, and consideration as a person of worth, sensitivity, and dignity;

12. Is encouraged, and informed of appropriate means as necessary, throughout the period of stay to exercise his rights as a resident and as a citizen; to this end, he is free to voice grievances and recommend changes in policies and services, free of coercion, discrimination, threats or reprisal;

13. Is permitted to retain and use his personal clothing and possessions as space permits unless to do so would infringe upon rights of other residents;

14. Is encouraged to function at his highest mental, emotional, physical and social potential;

15. Is free of physical or mechanical restraint except in the following situations and with

appropriate safeguards:

a. As necessary for the residence to respond to unmanageable behavior in an emergency situation which threatens the immediate safety of the resident or others;

b. As medically necessary, as authorized in writing by a physician, to provide physical support to a weakened resident;

16. Is free of prescription drugs except where medically necessary, specifically prescribed, and supervised by the attending physician;

17. Is accorded respect for ordinary privacy in every aspect of daily living, including but not limited to the following:

a. In the care of his personal needs except as assistance may be needed;

b. In any medical examination or health related consultations the resident may have at the residence;

c. In communications, in writing or by telephone;

d. During visitations with other persons;

e. In the resident's room or portion thereof; residents shall be permitted to have guests or other residents in their rooms unless to do so would infringe upon the rights of other residents; staff may not enter a resident's room without making their presence known except in an emergency or in accordance with safety oversight requirements included in regulations of the State Board of Social Services;

f. In visits with his spouse; if both are residents of the residence they are permitted but not required to share a room unless otherwise provided in the residents' agreements;

18. Is permitted to meet with and participate in activities of social, religious, and community groups at his discretion unless medically contraindicated as documented by his physician in his medical record.

B. If the resident is unable to fully understand and exercise the rights and responsibilities contained in this section, the residence shall require that a responsible individual, of the resident's choice when possible, designated in writing in the resident's record, be made aware of each item in this section and the decisions which affect the resident or relate to specific items in this section; a resident shall be assumed capable of understanding and exercising these rights unless a physician determines otherwise and documents the reasons for such determination in the resident's record.

C. The residence shall make available in an easily accessible place a copy of these rights and responsibilities and shall include in them the name and telephone number of the regional licensing supervisor of the Department of Social Services as well as the toll-free telephone number for the Virginia Long-Term Care Ombudsman Program, any sub-state ombudsman program serving the area, and the toll-free number of the ~~Department for Rights of Virginians with Disabilities~~ *Virginia Office for Protection and Advocacy.*

D. The residence shall make its policies and procedures for implementing this section available and accessible to residents, relatives, agencies, and the general public.

E. The provisions of this section shall not be construed to restrict or abridge any right which any resident has under law.

F. Each residence shall provide appropriate staff training to implement each resident's rights included in this section.

G. The State Board of Social Services shall promulgate regulations as necessary to carry out the full intent of this section.

H. It shall be the responsibility of the Commissioner of Social Services to ensure that the provisions of this section are observed and implemented by adult care residences as a condition to the issuance, renewal, or continuation of the license required by this article.

§ 63.1-314.8. Technical Assistance Committee created; duties; membership.

A. There is hereby created a Technical Assistance Committee, which shall provide technical and support services on the operations of the information and referral system as the Council may deem appropriate and shall advise the Council in performing its powers and duties.

B. The membership of the Technical Assistance Committee shall include but not be limited to:

1. Two directors of local departments of public welfare or social services, one serving a rural and one an urban locality, to be appointed by the Commissioner of Social Services; and

2. The Commissioners or Directors, or their designees, of the Department of Medical Assistance Services; Department of Health; Department of Mental Health, Mental Retardation and Substance Abuse Services; Department of Rehabilitative Services; Department for the Aging; Department for the Visually Handicapped; ~~Department for Rights of Virginians with Disabilities~~ *Virginia Office for Protection and Advocacy*; Department of Information Technology; Department for the Deaf and Hard-of-Hearing; Department of Health Professions; Department of Corrections; Department of Education; Department of Juvenile Justice; and the Virginia Employment Commission.

2. That Chapter 8 (§§ 51.5-36 through 51.5-39) of Title 51.5 of the Code of Virginia is repealed.

3. That the Governor is hereby requested to designate the Virginia Office for Protection and Advocacy as the agency accountable for the proper use of funds for protection of and advocacy for persons with mental, cognitive, sensory, physical, or other disabilities as determined by federal and state law and as the state protection and advocacy agency to administer the Protection and Advocacy for Individuals with Mental Illness Program, the Developmental Disabilities Program, the Client Assistance Program, the Assistive Technology Program, and other federal and state programs for the protection and advocacy of the aforementioned persons.

4. That the provisions of this act shall not become effective until the Governor, pursuant to applicable federal statutes and regulations, completes the process for redesignation of the Virginia Office for Protection and Advocacy.

5. That the regulations of the Department for Rights of Virginians with Disabilities in effect on the effective date of this act shall continue in effect until such time as amended or repealed by the Virginia Office for Protection and Advocacy.

6. That the Governor may transfer an appropriation or any portion thereof or any employees within an agency established, abolished or altered by the provisions of this act, or from one such agency to another, to support the changes in organization or responsibility resulting from or required by the provisions of this act.

7. That as of the effective date of this act, the Virginia Office for Protection and Advocacy shall be deemed the successor in interest to the Department for Rights of Virginians with Disabilities to the extent that this act transfers powers and duties. All right, title and interest in and to any real or tangible personal property vested in the Department for Rights of Virginians with Disabilities to the extent that this act transfers powers and duties as of the effective date of this act shall be transferred to and taken as standing in the name of the Virginia Office for Protection and Advocacy.

Official Use By Clerks

Passed By The House of Delegates		**Passed By The Senate**	
without amendment	☐	without amendment	☐
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐

Date: _____ Date: _____

_____ _____

Clerk of the House of Delegates Clerk of the Senate

003954756

HOUSE BILL NO. 1475

Offered January 24, 2000

A BILL to amend the Code of Virginia by adding in Title 9 a chapter numbered 51, consisting of sections numbered 9-390 through 9-395, relating to the Joint Commission on Behavioral Health Care.

Patrons—Hall, Bloxom, Christian, DeBoer, Grayson, Morgan, Thomas and Weatherholtz; Senators: Hanger, Martin and Wampler

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Referred to Committee on Rules

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Title 9 a chapter numbered 51, consisting of sections numbered 9-390 through 9-395, as follows:

CHAPTER 51.

JOINT COMMISSION ON BEHAVIORIAL HEALTH CARE.

§ 9-390. Joint Commission created.

There is hereby created, as a legislative agency, the Joint Commission on Behavioral Health Care, hereinafter referred to as the Commission. The purpose of the Commission is to study, report and make recommendations for continuous improvement in all areas of publicly funded behavioral health care policy, management, financing, service delivery, regulation and evaluation. The Commission shall endeavor to ensure that the Commonwealth as financier, regulator, and provider adopts the most cost-effective and efficacious means of delivering behavioral health care so that the greatest number of Virginians in need of care receive quality behavioral health care. Further, the Commission shall encourage the development of uniform policies and services to ensure the availability of quality, affordable and accessible behavioral health care services and provide a forum for continuing the review, study and improvement of programs and services.

The Commission shall cooperate and collaborate with the Joint Commission on Health Care as established in §9-311 on matters of mutual concern.

The Commission may make recommendations and coordinate the proposals and recommendations of all commissions and agencies as to legislation and budget amendments affecting the delivery of publicly funded behavioral health care.

§ 9-391. Membership; compensation.

The Commission shall be composed of nineteen members: five members and two former members of the Senate, to be appointed by the Senate Committee on Privileges and Elections; eight members and one former member of the House of Delegates, to be appointed by the Speaker of the House; and the Secretary of Health and Human Resources, the Commissioner of Mental Health, Mental Retardation and Substance Abuse Services and the Director of Medical Assistance Services, who shall serve ex officio without voting privileges.

The term of each appointee shall be for five years. Whenever any legislative member fails to retain his membership in the house from which he was appointed, his membership shall be vacated, and the vacancy shall be filled in the original manner. The members of the Commission shall elect a chairman and vice chairman.

Members of the Commission shall receive compensation as provided in § 30-19.12 and shall be paid their necessary expenses incurred in the performance of their duties. All such expense payments, however, shall come from existing appropriations to the Joint Commission on Behavioral Health Care.

§ 9-392. Duties and powers.

The Commission shall have the duty and power to study and to gather information and data to accomplish its purpose as set forth in § 9-390 and to report its recommendations to the Governor and the General Assembly.

The Chairman of the Commission shall have the authority to invite other interested parties to sit with the Commission and to participate in its deliberations.

The Commission shall study the operations, management, jurisdiction, powers and

interrelationships of any department, board, bureau, commission, authority or other agency with any direct responsibility for the provision and delivery of behavioral health care in the Commonwealth.

The Commission shall examine matters relating to health services in other states and shall consult and exchange information with officers and agencies of other states with respect to behavioral health service problems of mutual concern. The Commission may maintain offices and may hold meetings and functions at any place within the Commonwealth as it may deem necessary.

§ 9-393. Staff and staff support.

The Commission shall be authorized to appoint, employ, and remove an executive director and such other persons as it may deem necessary and to determine their duties and fix their salaries or compensation within the amounts appropriated therefor. The Commission may also obtain such assistance as it may deem necessary from other legislative and executive agencies and may employ experts who have special knowledge of the issues before it.

§ 9-394. Annual report.

The Commission shall make an annual report to the Governor and the General Assembly which shall include its recommendations. The Commission shall make such further interim reports to the Governor and the General Assembly as it shall deem advisable or as shall be required by the Governor or the General Assembly.

§ 9-395. Sunset.

The provisions of this chapter shall expire on July 1, 2005.

Official Use By Clerks

Passed By The House of Delegates		**Passed By The Senate**	
without amendment	☐	without amendment	☐
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐

Date: _____ Date: _____

_____ _____

Clerk of the House of Delegates Clerk of the Senate