Biennial Report

State Executive Council

Comprehensive Services for At-Risk Youth & Families

December 20, 2005

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A. Background

Biennial Report Mandate

Virginia Code *(§ 2.2-2648.19)* requires that the State Executive Council of Comprehensive Services for At-Risk Youth and Families:

> *"Biennially publish and disseminate to members of the General Assembly and community policy and management teams a state progress report on comprehensive services to children, youth and families and a plan for such services for the next succeeding biennium. The state plan shall:*
>
> *a. Provide a fiscal profile of current and previous years' federal and state expenditures for a comprehensive service system for children, youth and families;*
> *b. Incorporate information and recommendations from local comprehensive service systems with responsibility for planning and delivering services to children, youth and families;*
> *c. Identify and establish goals for comprehensive services and the estimated costs of implementing these goals, report progress toward previously identified goals and establish priorities for the coming biennium; and*
> *d. Include such other information or recommendations as may be necessary and appropriate for the improvement and coordinated development of the state's comprehensive services system."*

This report provides the statutory and historical context for CSA. It focuses primarily on the children served, services provided, and expenditures during FY 2005. In addition, it highlights the strategic directions and priorities for CSA. It concludes with a summary of the major accomplishments and improvements made during the past four years to improve the CSA system of services and funding.

CSA Statutory Framework

The purpose of the Comprehensive Services Act for At-Risk Youth and Families *(CSA)* is to create a collaborative system of services and funding that is child-centered, family-focused, community-based and cost-effective when addressing the strengths and needs of troubled and at-risk youths and their families in the Commonwealth *(§ 2.2-5200)*. A primary purpose of the law is to preserve and strengthen families through providing appropriate services in the least restrictive environment, enabling children to remain in their homes and communities when possible, while protecting the welfare of children and maintaining public safety.

The State Executive Council *(SEC)* serves as the supervisory council that provides leadership for CSA *(§2.2-2648)*. It oversees the development and implementation of state interagency program

and fiscal policies. The SEC is chaired by the Secretary of Health and Human Resources or a designated deputy. It is comprised of two General Assembly members, state government agency heads *(from the five child serving agencies, the Virginia Department of Medical Assistance Services, and the Office of the Executive Secretary of the Supreme Court)*, two local government officials, the chair of the State and Local Advisory Team, and representatives from parents and private provider association. *(See Appendix A for list of SEC members.)*

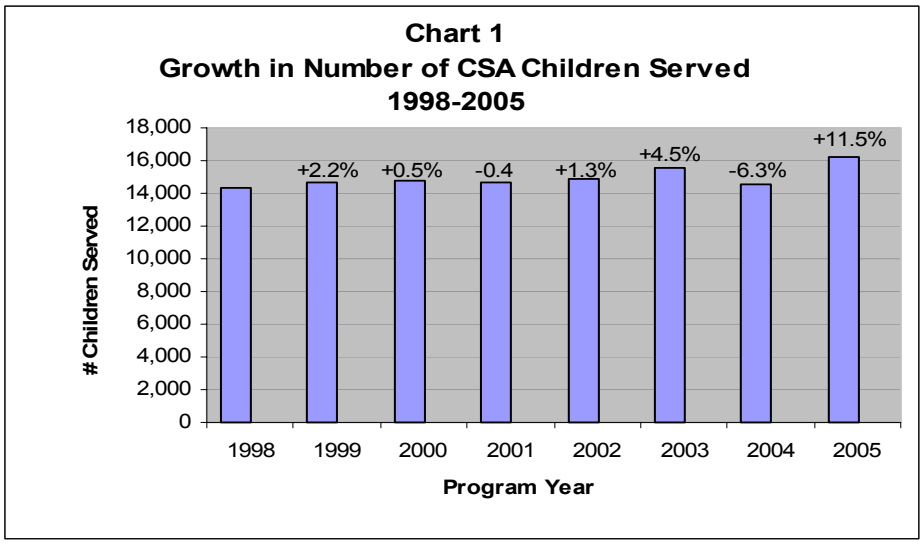
The CSA System is comprised of several other entities at the state and community levels that work collaboratively to implement CSA. At the state level, the State and Local Advisory Team *(SLAT)* advises the SEC by managing cooperative efforts at the state level and providing support to community efforts. The Office of Comprehensive Services for At Risk Youth and Families *(OCS)* serves as the administrative entity of the SEC and ensures that its decisions are implemented.

In each community across the Commonwealth, teams of professionals and family members collaboratively decide how to provide services and funding for children and their families. The Community Policy and Management Teams *(CPMTs)* have the statutory authority and accountability for managing the cooperative effort and developing interagency policies that govern CSA in the community. Family Assessment and Planning Teams *(FAPTs)* are established by CPMTs to provide for family participation, assess the strengths and needs of children and their families, develop individual family services plans, and make recommendations to the CPMTs. CSA Coordinators are hired by many, but not all, communities to manage local CSA implementation. *(See Appendix B for description of CSA state and local structures.) (See Appendix C for web links to additional CSA information.)*

B. Demographic and Service Profile of CSA Children in FY 2005

Children Served

In FY 2005, CSA served 16,272 children statewide *(unduplicated)*. Historically, the number of children served has increased on average 2% annually over the past eight years *(See Chart 1)*.



In FY 2004, the number of children served was underreported due to implementation of the new CSA data set, which now serves as the source for this data. During the first year of implementation, a few localities did not report children who were placed in family foster care. Correcting for this underreporting, the number of children served in FY 2005 is consistent with historical increases of about 2.24% in both FY 2004 and FY 2005.

While the CSA population was varied in FY 2005, teenage males from high density localities were the typical recipients of CSA-funded services. Demographics included:

- 59% of CSA children were male; 41% were female.
- 53% were Caucasian; 43% were African American; 4% undetermined.
- 5% were Hispanic.

Many CSA children had significant and complex problems. Forty-four percent of all CSA children had a mental health diagnosis; one-third *(33%)* took psychotropic medications. The most prevalent reasons that caseworkers reported for providing services for children and their families at the last assessment were:

- 41% due to parental neglect, physical abuse, caregiver incapacity, and caregiver absence;
- 16% for special education issues;
- 16% for emotional, mental health, or substance abuse problems; and
- 15% for behavioral problems.

Most children were originally referred to CSA by either local departments of social services *(61%)* or the schools *(20%),* since children in foster care and special education represent mandated populations required by federal law to receive sum sufficient funding for needed services. Fewer referrals came from local court service units *(8%)* and from community service boards *(4%)*.

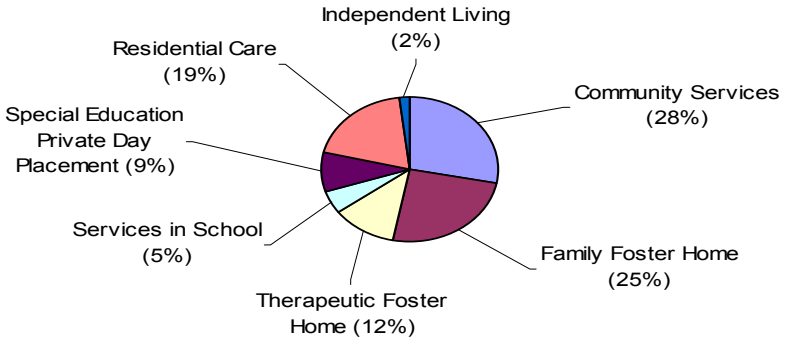
Array of CSA Services Provided

CSA children received a broad range of services during FY 2005. The 16,272 CSA children actually received 25,242 services during the year. Thus, many children received more than one service. *(See Appendix D for description of CSA services, including percentage of all CSA services provided.)*

Over two-thirds *(70%)* of all CSA services were provided in family settings, the schools and in the community. *(See Chart 2)*

- 37% of all CSA services were family-like settings *(family foster homes and therapeutic foster homes);*
- 28% were community-based services; and
- 5% were services provided in the public schools to prevent more restrictive and expensive educational placements.

Chart 2
Type and Percent of All CSA Services
Program Year 2005



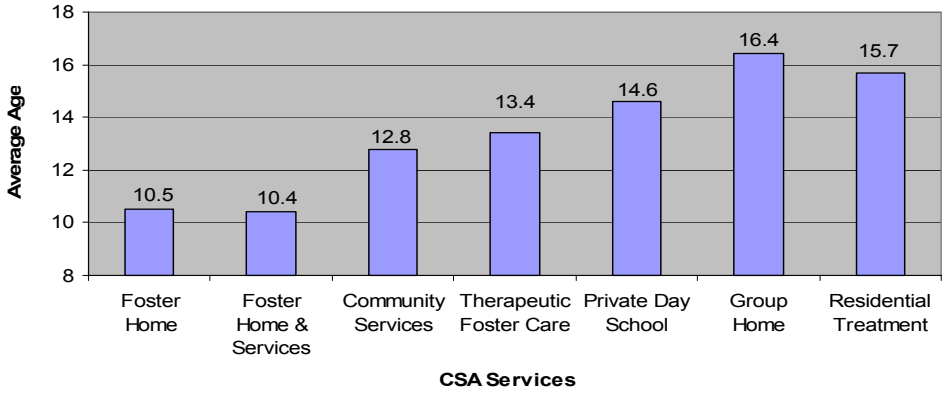
Almost one out of five *(19%)* CSA services were licensed residential care settings.

- 12% were secure residential facilities and campus-style residential programs where the facility provided 24-hour supervised care and intensive treatment services;
- 7% were group homes that provided supervision in homelike environments for groups of children with behavioral, emotional, physical and/or mental disabilities; and
- Less than 1% were psychiatric hospitals.

In analyzing the profiles of CSA children served in the different types of services during FY 2005, the data reveal several trends.

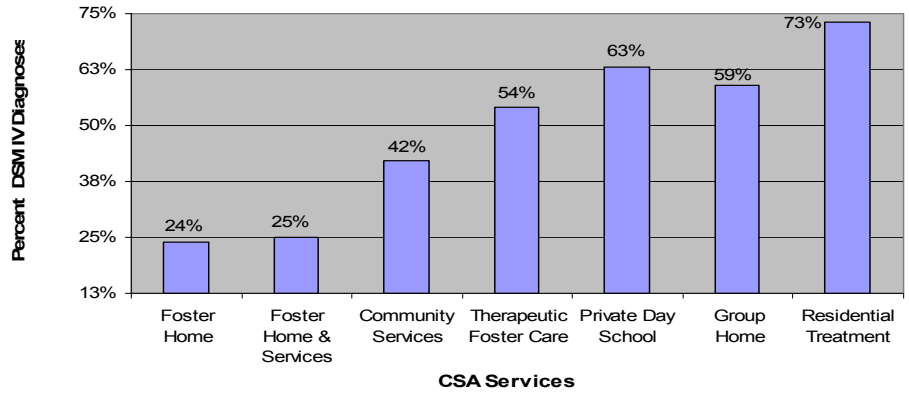
First, the average age of children was higher in more restrictive services *(14-16 years old)* than in family and community settings *(10-13 years old),* corresponding to the increased intensity of the service *(See Chart 3).* The age peaked at an average of 16.4 years of age in group homes. These placements were often used to transition children from residential treatment facilities.

Chart 3
Average Age of Youth
& Level of CSA Services



Second, the percent of children with diagnosed mental health disorders was higher in more intensive services than in regular foster care *(See Chart 4)*. Almost three out of four children placed in residential facilities had diagnoses, as did almost two-thirds of children placed in special education private day programs. Over half of children in group homes and therapeutic foster care homes had diagnoses. In contrast, only one out of four children in regular foster care services had mental health diagnoses.

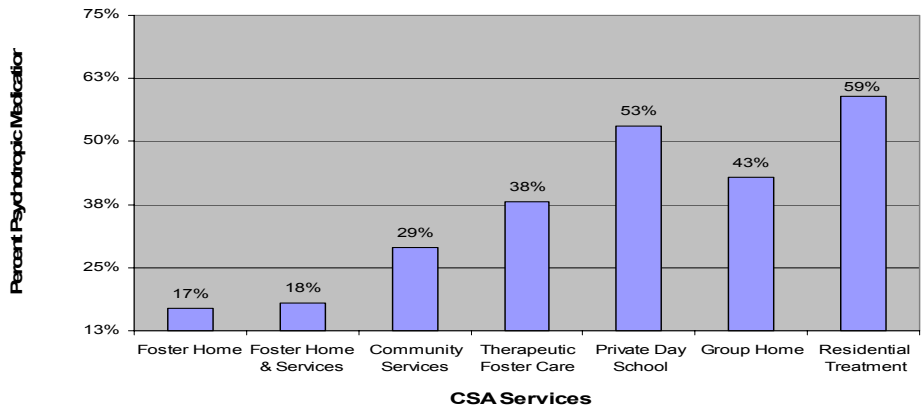
Chart 4
DSM IV Diagnoses*
& Level of CSA Services



*Based on diagnoses in Diagnostic and Statistical Manual of Mental Disorders *(DSM-IV)*

Third, the percent of children receiving psychotropic drugs was also higher in more intensive services than in regular family foster homes. Over half of children placed in special education private day programs and residential facilities were on prescription medications for mental health problems. In contrast, less than 20% of children in regular family foster homes received medications. Almost one-third of children that received community services or therapeutic foster care services had received medications.

Chart 5
Psychotropic Medication
& Level of CSA Services



Thus, during FY 2005, the data show that younger children, averaging 10-13 years old, tended to be served in family-like settings and received community based services through CSA. Older children, averaging 14-16 years old with mental health diagnoses and prescribed psychotropic medications, tended to be placed in private day schools, group homes and residential treatment facilities. Communities reported that these older children were difficult to serve in school and family settings due to their emotional and behavior problems combined with adolescence.

C. Historical and FY 2005 CSA Expenditures

Framework for CSA Funding

The 1993 Comprehensive Services Act simplified funding for troubled and at-risk youth by combining eight funding streams *(each with a different local match rate)* across four agencies into one CSA state funds pool. The statute *(§2.2-5211)* specifies the purposes of this funding system as:

- Placing authority for making program and funding decisions at the community level;
- Consolidating categorical agency funding and instituting community responsibility for the provision of services;
- Providing greater flexibility to communities in the use of funds to purchase services based on the strengths and needs of youth and their families; and
- Reducing disparity in accessing services and reducing inadvertent fiscal incentives for serving children according to differing required local match rates for funding streams.

The statute states that it is "not intended that children be categorized by individual funding streams in order to access services."

CSA funds may be used to purchase public or private services for children and their families. Each agency continues to be responsible for providing services that are within their normal scope of responsibility and that are funded separately from the state pool.

The Appropriations Act *(Item 299.C)* specifies the funding formula for allocating CSA state pool funds to community policy and management teams. Localities may receive supplemental allocations to meet the service needs of children and their families. All localities must appropriate a local match. The average local match is 37%; the average state share is 63%. *(See Attachment E for CSA funds in the Appropriations Act from FY 2004 through FY 2006.)*

Federally and State Mandated Program for Children

Special education and foster care children are mandated populations required by federal law to receive sum sufficient funding for needed services *(§2.2-5211C)*. When circumstances beyond the community's control bring additional mandated youth and there are insufficient funds to pay for necessary services, the community and state must pay their respective share of cost for those services. This sum sufficient provision was required prior to the enactment of the CSA when local school boards or social services departments funded services for these children in their respective agency budgets.

For the CSA special education population, federal law *(Individuals With Disabilities Act, IDEA; 20 U.S.C. 140 et.seq)* requires that state and local governments pay for services cited in the child's individual education plan. The Comprehensive Services Act *(§2.2.5212)* includes in its target population those youth placed for purposes of special education in approved private school educational programs. Finally, the Virginia Special Education Regulations *(8 VAC 20-80 et.seq)* and the Code of Virginia *(§22.1 et.seq)* specify local school division responsibilities for providing special education and related services to eligible students with disabilities.

State statute along with federal regulation serve as the foundation for the foster care funding mandates. Children are also mandated to receive foster care services in order to prevent foster care placements, when they are entrusted to local social services agencies or committed by the court, or when they are placed with a local public agency by the CPMT through an agreement where custody is retained by the parent or custodian for purposes of placement *(§63.1-55.8)*.

Historical and FY 2005 Expenditures on CSA Children

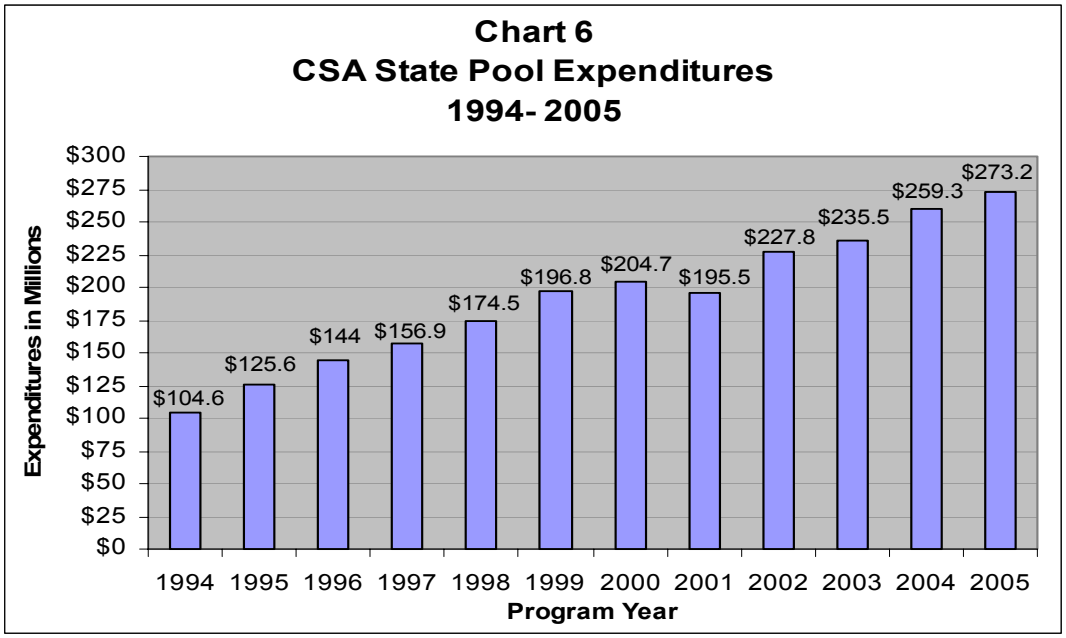
While OCS' projections of CSA expenditures and caseloads have historically been accurate, it is inherently difficult to forecast CSA costs at the state and local level due to the nature of the program. CSA costs are driven by multiple factors, many beyond local and state control, including:

- Number of mandated children in the community;
- Severity of problems;
- Availability, type and duration of services;
- Service rates;
- Availability of alternative funding sources;
- Local practices; and
- Policy changes.

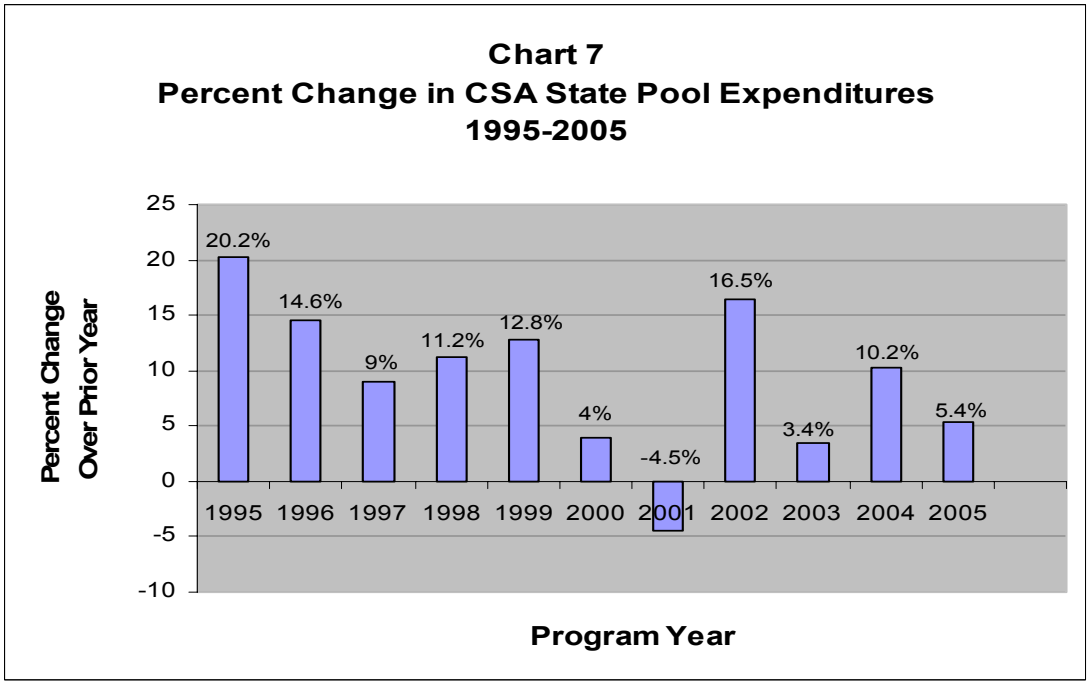
The cost of just one child can unexpectedly place significant strain on a community's budget.

In FY 2005, CSA state pool expenditures totaled $273.2 million *(state and local funds)* for services provided to children and their families from July 1, 2004 through June 30, 2005. This represented a 5.4% increase over FY 2004 when CSA state pool expenditures totaled $259.3 million. (*See Appendix F for expenditures and census by locality for FY2005 and FY2004.)*

CSA state pool expenditures have increased steadily for state and local governments from $104.6 million in 1994 to $273.2 million in 2005 (*see Chart 6).* (See *Appendix G for historical statewide summary of CSA census and expenditures from FY 1994 through FY 2005.)*

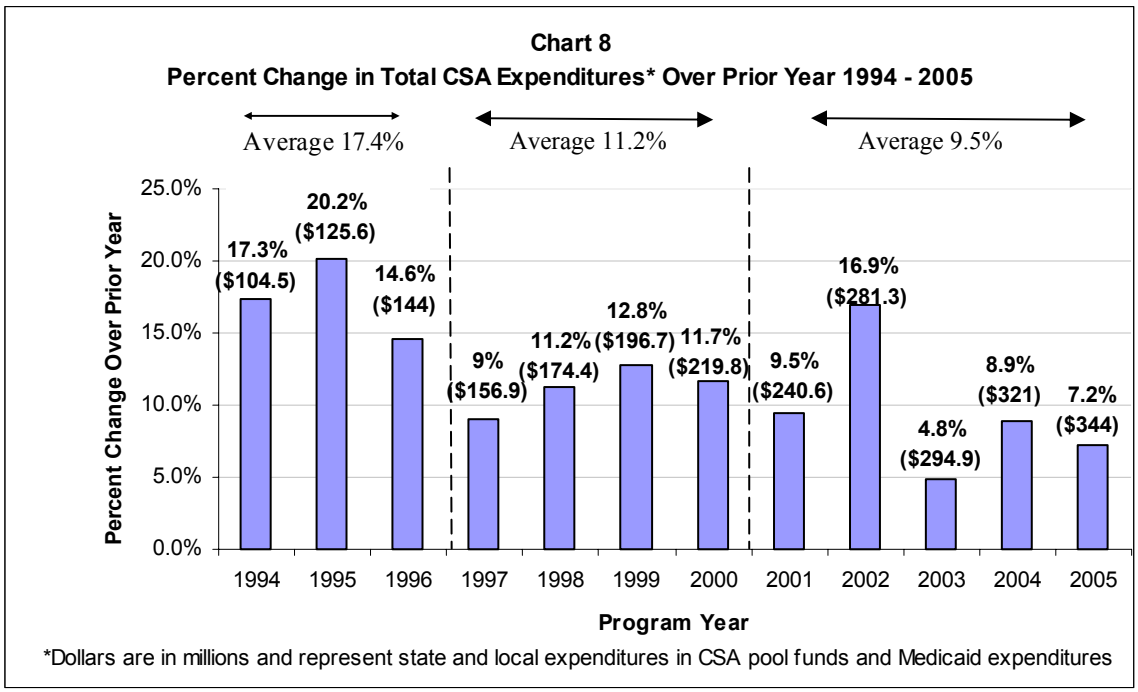


There have been dramatic fluctuations over the past eleven years in the percentage change in CSA state pool expenditures *(state and local dollars)* over the prior year. Changes have ranged from a 20.2% increase in 1995 to a 4.5% decrease in 2001 over the respective prior years *(See Chart 7)*.



Prior to CSA, program costs increased at a rate of 22% annually from FYs 1989-1993, except for a one year drop from FYs 1991-1992 *(Joint Legislative Audit and Review Commission Report, 1998)*.

Since the implementation of CSA, the rate of increase in total expenditures has declined *(See Chart 8)*. During the first three years of CSA implementation from 1994 to 1996, state and local expenditure growth averaged 17.4% annually. During the next 4 years *(1997 through 2000),* the average annual rate of increase declined to 11.2%. Since 2000 with the introduction of Medicaid and the use of federal Title IV-E funds for CSA Children, the average annual rate of increase for total CSA expenditures *(state, local and Medicaid)* has been 9.5%.



Utilization Management for All CSA Services

To ensure the appropriate use of CSA funds and that services effectively meet the needs of children and their families, the Appropriations Act *(Item 200.B.3)* requires each locality receiving CSA funds to have a utilization management process for all CSA services. Utilization management includes analyzing assessment and placement information to guide service decisions, assessment of the necessity, efficiency and appropriateness of services provided, as well as discharge planning. Several localities have hired utilization review staff. For 73 smaller localities, the Virginia Department of Medical Assistance Services *(DMAS)* contracts for state utilization review services of residential placements for CSA youth who are not Medicaid eligible.

Maximizing the Use of Federal Funds

State and local governments have made significant strides in maximizing the use of federal funds to support CSA services and to minimize the overall annual growth rate in CSA funding. Efforts have focused primarily on maximizing Medicaid and Title IV-E funds. During FY 2005, localities screened 73% of all CSA children for Medicaid and 59% for Title IV-E funds. Not all CSA youth should be screened for eligibility due to their "mandated" status and/or services provided *(e.g., CSA children that receive only special education services are not eligible).*

In 2000, Medicaid policy was changed to allow Medicaid funding for residential treatment and therapeutic foster care. Since the introduction of Medicaid to offset some of CSA costs, over $158 million in federal funds has been used to pay for CSA children. These costs were previously paid with state and local funds. For FY 2005, Medicaid expenditures for CSA children totaled $70.8 million *(50% federal; 32% state; on average 18% local match)* based on service billings from July 1, 2004 through June 30, 2005.

- $54.3 million on residential treatment facilities *(not including campus style settings);*
- $13.7 million on treatment foster care; and
- $2.8 million on group homes.

In addition, Medicaid funds a continuum of community mental health services for all Medicaid children, including eligible CSA children.

Title IV-E expenditures totaled $67.1 million *(50% federal; 50% state)* from June 2004 to May 2005 according to the Virginia Department of Social Services. It is difficult to determine the percent of these expenditures spent exclusively on CSA children. However, had these funds not been available, state and local governments would have been required to cover these costs through the CSA pool funds *(with the average state share at 63%; average local share at 37%).*

External Issues Have Fiscal Impact Beyond CSA Control

Since CSA is purposefully designed to be integrated with other state and local agencies, policy and fiscal changes impacting these agencies often impacts CSA as well. Three potential changes that could impact CSA in the future are in the areas of Medicaid, Title IV-E, and the Virginia Department of Social Services' Program Improvement Plan.

Medicaid. The reliance on the increased use of Medicaid funding has been a major focus in the effort to reduce the increase in CSA costs. With discussions at the federal level focusing on limiting federal Medicaid costs, any policy changes that would reduce Medicaid reimbursement for CSA services will increase state and local CSA costs. The FY05 federal share of Medicaid expenditures was approximately $38.1 million.

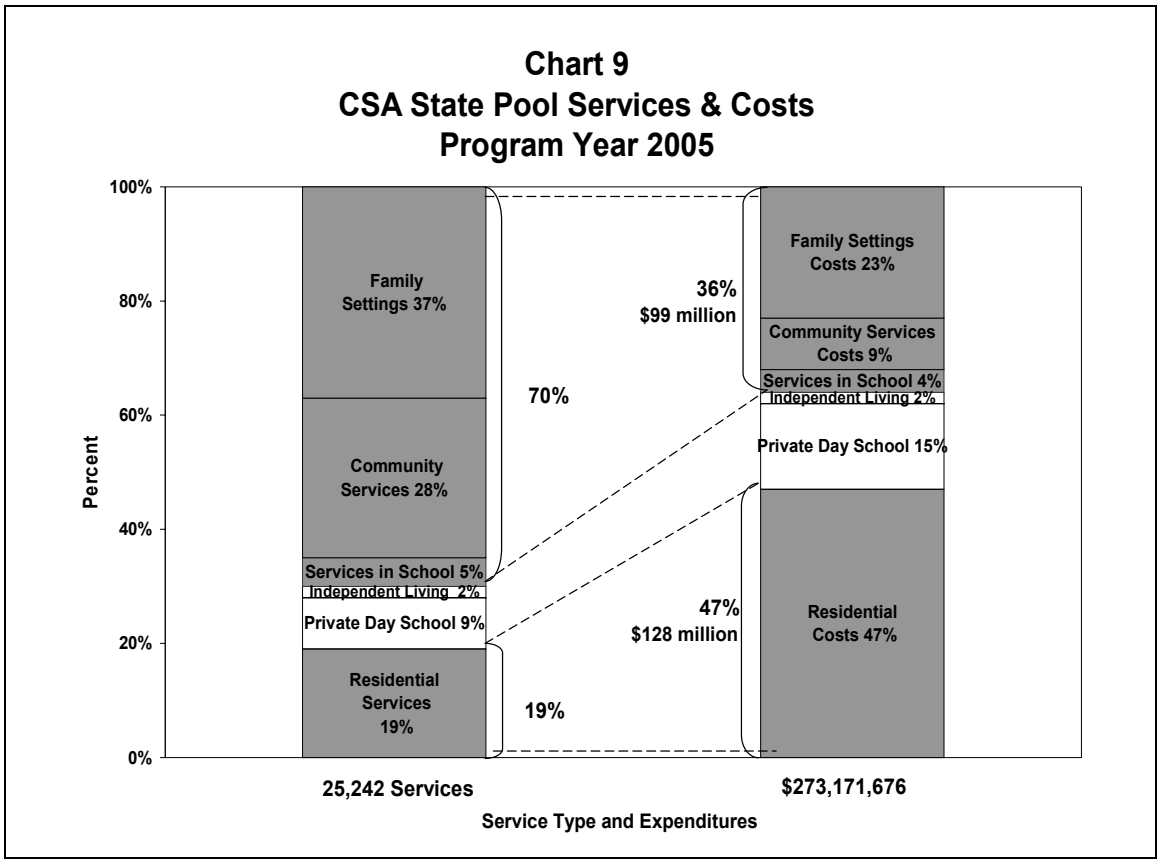
Title IV-E Funding. The Virginia Department of Social Services and the federal government have been discussing the disallowance of certain title IV-E federal reimbursement claims. The loss in the Commonwealth's ability to utilize certain federal Title IV-E funding could negatively impact CSA financially. The local services funded through this funding source have benefited CSA, off setting state pool cost. Should the use of some of these funds be disallowed or limited, demand for state and local CSA funds will increase.

Program Improvement Plan (PIP). The increased responsibilities for local and state child welfare agencies serving children in foster care as a result of the 2003 Child and Family Services Review will directly impact CSA. Almost two-thirds of all CSA referrals come from local departments of social services *(61%)* in FY 2005.

CSA Expenditures by Service Type for FY 2005

Over $99 million in CSA pool funds was spent on services in family settings, the community and the schools, representing 36% of total CSA pool costs. These funds were expended on 70% of all CSA services provided. *(See Chart 9)*

- $48 million was spent on therapeutic foster homes for 3,036 children, representing 18% of all CSA pool expenditures.
- $25 million was spent on community services for 6,922 children, representing 9%.
- $15 million was spent on family foster homes, representing 5% of expenditures.
- $11 million was spent on services in the schools for 1,156 children to prevent more restrictive and expensive educational placements, representing 4% of expenditures.



Over $128 million in CSA pool funds was spent on residential services, representing almost half *(47%)* of all CSA state pool expenditures *($273.2)*. These funds were expended on 19% of all CSA services provided. During FY 2005, state and local governments spent:

- $92 million on secure residential treatment facilities and campus style residential programs for 3,029 children, representing over one-third *(34%)* of all CSA funds pool expenditures;
- $35 million on group homes for 1,717 children, representing 13%; and
- $1 million on psychiatric hospitals for 99 children, representing 0.6%.

Additional Medicaid expenditures were spent on CSA children in residential facilities and group homes, totaling $57.1 million based on service billings from July 1, 2004 through June 30, 2005. *(This represents 50% federal; 32% state; and on average 18% local match.)*

- $54.3 million was spent on residential treatment facilities *(not including campus style settings)*; and
- $2.8 million was spent on group homes.

Thus, over $185 million in state, local and federal funds was spent on residential care in FY 2005 for CSA children. These costs do not include federal IV-E expenditures and other Medicaid services paid for CSA children during these placements.

One out of every four CSA children *(25%, or 4,046 of 16,272 children)* was placed in residential care at some point during the year. Some of these children were placed in more than one type of residential setting. *(See Appendix H for number of children in residential care by locality; see Appendix I for FY 2005 total residential care expenditures by locality.)*

There are multiple reasons why a community may have had a relatively higher percentage of children placed in residential care than other communities, including:

- The CSA caseload for the community may have been small, thus one or two children in residential care comprised a larger percentage of the total caseload than communities with more children.
- Some smaller communities report that it is not economically feasible to develop specialized services locally for a small number of children.
- Some communities report having access to a broader array of services locally or regionally, thus the children served through CSA were the ones requiring more intensive services.
- A residential care provider may have effectively served children in that community.

While residential care is an important part of a continuum of care, many localities report that they are not able to effectively serve some CSA children in the community. Rather, these children are placed in more restrictive, out-of-community care than necessary, resulting in higher costs. Communities report needing:

- Community-based services to prevent placements of children in more restrictive settings outside of their communities than necessary.
- Private and public providers who are willing to develop specialized, wraparound services tailored to meet the needs of difficult children and their families.
- Start-up funds for developing services in family settings, the schools, and the community.
- Pooling funds across several communities to provide economies of scale to develop services.
- Expertise in conducting assessments, developing creative service plans, and providing care coordination for children with serious emotional and/or behavior problems and their families to effectively serve them in the community.
- Clinical expertise to assess the necessity, appropriateness and effectiveness of continued placement in residential care and to assist with discharge planning to reduce length of stay.

Many communities in Virginia and across the country are striving to effectively serve children with serious emotional and behavior problems in the community through less restrictive and less costly services. The state of Arizona instituted several systemic changes to reduce the number of children placed in out-of-home care *(hospital, residential group home, and behavioral health group home)*.

- In September 2003, 1,260 children were placed in out-of-home care, accounting for 39% of the statewide service budget.
- Two years later, 850 children were in out-of-home care, accounting for 20% of the service budget. Forty percent of these children were served in family-settings rather than congregate care.

Arizona reports that they accomplished this reduction by:

- Developing community services *(e.g., therapeutic foster care, multisystemic therapy, placement- and crisis-stabilization resources)* that allowed children to be appropriately served in family-based settings despite high support and treatment needs.
- Instituting clinical practices to help child and family teams develop individualized plans for children with challenging problems to avoid or reduce length of stay in congregate care placements.
- Allowing providers that host child and family teams to reinvest savings from averted residential placements to build community capacity.

D. State Progress & Priorities

Action Plan of the Secretary of Health and Human Resources

In 2002, the Secretary of Health and Human Resources appointed a Steering Committee and task groups consisting of legislators, public and private stakeholders, and state and local partners to address key CSA issues. They developed a blueprint for action to reform key aspects of CSA. The plan addressed the following areas:

- Allocation methodologies, reimbursement procedures, and cost sharing formulas for localities;
- CSA state organization and structure;
- Strategies for increasing collection of federal reimbursement;
- Managing, evaluating and monitoring care in CSA;
- Managed care as an option for CSA;
- Negotiated statewide contracts for services purchased by state and local agencies;
- Coordinated collection of information among state agencies; and
- Projections of caseloads, service needs, and costs.

In October 2002, the Secretary submitted a blueprint for action, entitled *"A Plan for Improving Services and Containing Costs in the Treatment and Care of Children Under the Comprehensive Services act for At-Risk Youth and Families"* to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees *(see Appendix J for report introduction)*. In October 2003, the Secretary submitted a progress report detailing actions implemented *(See Appendix K)*.

SEC Strategic Directions

In April 2004, the SEC established five strategic directions to further its mission of directing a cost-effective system of services for youths that is child-centered, family focused and community based *(see Appendix L for the SEC strategic plan)*. These strategic directions are:

- To develop policies that improve access to care for all at-risk and troubled youth and their families.
- To promote open communication, ownership, and active participation among all CSA participants: parents and their children, local and state decision makers and governments, and private agencies.
- To maximize and efficiently utilize all available local, state, federal and private funding streams that are aligned with and complementary to Comprehensive Services Act principles.
- To develop and implement a quality improvement program that uses customer feedback, client outcomes, and program and fiscal data to improve the operation and management of CSA, OCS, and SEC.
- To develop program efficiencies and support that minimize CSA administrative processing and expenses at all levels: state, local, and private agencies.

SEC Retreat & Priorities

In April 2005, the State Executive Council held a retreat of key CSA Stakeholders. It included parents, private providers, local government officials, judges, state and local child serving agencies, Virginia Department of Medical Assistance Services, the Office of the Executive Secretary of the Supreme Court, the Office of the Secretary of Health and Human Resources, SLAT members, CSA Coordinators and OCS.

Several themes emerged from the SEC retreat that serve as priorities for OCS and SLAT, within the overall framework of the SEC's five strategic directions. These priorities are to:

- Involve families more proactively throughout CSA.
- Improve the capacity of communities to implement CSA:
    - Provide increased state guidance on policy and program implementation;
    - Increase technical assistance, training, and the sharing of best practices across agencies and associations;
    - Streamline local administrative requirements to reduce local workload burdens while improving services; and
    - Improve the CSA required utilization management processes.
- Manage CSA's strong financial infrastructure, while maximizing all available resources and minimizing the annual growth rate in CSA funding.
- Enhance communication with all CSA stakeholders.
- Provide management information to enhance decision making.

E. Major Accomplishments and Improvements

There have been major accomplishments resulting from the leadership provided by the State Executive Council. Significant improvements have been made in the areas of CSA state organization, program, technical assistance and training, financing, and management information.

State Organization

- Legislation was adopted by the 2003 General Assembly requiring:
    - The SEC be chaired by the Secretary of Health and Human Resources, or a designated deputy; and
    - The SLAT be chaired by a local government representative.
- Legislation was adopted by the 2005 General Assembly adding two legislators to the SEC *(one member from the House of Delegates; one member from the Senate).*
- An Executive Director for OCS was hired in January 2005 to build upon CSA's strong financial infrastructure and to help take CSA to the next level. CSA had grown significantly since its inception with significant demands.
- OCS' organizational structure was aligned with its mission, vision and priorities during calendar year 2005. The organization was streamlined and flattened, consolidating its financial, data, and business functions. Increased focus was placed on providing technical assistance to communities.
- A CSA dispute resolution process was instituted administratively.

Program

- Two reports with recommendations were submitted by the SEC's Workgroup on the Relinquishment of Custody for the Purpose of Accessing Behavioral Health Treatment to the Chairmen of the House Appropriations and the Senate Finance Committees and to the Chairman of the Joint Commission on Heath Care *(see Appendix M for November 2005 report and the findings and recommendations from the November2004 report).*
- SLAT has become more proactive in three areas:
    - Analyzing and recommending improvements in interagency policy and programs to the SEC;
    - Coordinating implementation of major agency initiatives that impact CSA; and
    - Operationalizing SEC decisions in its member agencies and associations.
- A new contract is being negotiated to improve the state-sponsored utilization management review of residential placements for CSA children who are not Medicaid eligible. This is part of the Virginia Department of Medical Assistance Services' prior authorization and utilization management contract. A major goal for CSA in this contract is to provide technical consultation and clinical expertise to participating localities so that CPMTs can make the most appropriate, cost-effective care decisions based on sound utilization management information. OCS will also assume management of the CSA component of the contract, working collaboratively with local CSA systems.
- Increased collaboration has been implemented at the state and regional levels with CSA Coordinator networks and private provider associations.

Training, Technical Assistance and Best Practices

- Increased focus is being provided to support local CSA systems with technical assistance, peer consultation, best practices and tools to improve CSA. OCS Technical Assistance Coordinators were assigned to geographic regions.
    - On-site visits, phone consultations, and regional roundtables are helping to identify strengths, challenges, and best practices of local CSA systems and are being shared with other communities.
    - Customized data profiles, charts and analyses are being used to assist CPMTs and FAPTs with their utilization management processes.
- A model utilization management plan, standard provider contract, and model individual family services plan were developed in collaboration with key stakeholders, incorporating best practices from communities and states.
- Additional technical assistance tools have been developed, including strengths-based assessment, goal setting, discharge planning, team collaboration, utilization management, and information for families.
- Best practices identified by localities have been posted on the CSA website.
- An on-line training module to orient new CSA Coordinators was developed.
- Trainings on Medicaid/FAMIS, Title IV-E and CSA topics were implemented.

Financing

- The Virginia Department of Medical Assistance Services added treatment foster care case management and additional residential coverage with two levels of step-down care.
- The Virginia Department of Social Services worked to enable localities to claim certain administrative and maintenance expenditures that were not previously allowed under Title IV-E.
- The Department of Social Services convened a federal maximization stakeholder group that unbundled some IV-E services.
- OCS posts grant announcements on its website to inform localities of alternative funding sources from non-profit organizations and federal and state agencies.
- Any new state general funds for the CSA funds pool are appropriated to the base allocations of localities, rather than set aside to support the state share of supplemental requests. Historically, base allocations have been insufficient to serve mandated populations, requiring localities to often request supplemental funds. The purpose of this policy change was to reduce the number of supplemental submissions over time.
- OCS simplified and streamlined the process required for localities to use when requesting supplemental funds.

Management Information

- A new CSA data set was implemented on July 1, 2003, providing demographic, service and expenditure information on all children receiving CSA funded services.
- Accurate expenditure data by child for all CSA services provided during the program year was implemented during FY 2005. This was accomplished by extending the reporting date to include all year end expenditures and reducing the number of reports submitted by local governments annually from four to three reports.

- Access to the statewide data set information was provided to localities, allowing them to prepare analyses to meet the needs of their respective local governments. This was accomplished with assistance from the Department of Social Services.
- All CSA financial reporting information is now communicated using a web based application, eliminating papers and forms.
- All requests for increases in locality allocations are communicated electronically through a separate web application, developed and supported by OCS.
- The web-based CSA service fee directory was updated to include licensing information as well as discrete service and rate information.

These significant improvements mark only the beginning in realizing the full potential of CSA. The State Executive Council, in close collaboration with all CSA stakeholders, shall continue its ambitious and aggressive action plan to further improve the CSA system of services and funding for troubled and at-risk youth and their families across the Commonwealth.

State Executive Council Members
Comprehensive Services For At-Risk Youth and Families
December 2005

Office of Health and Human Resources
Jane H. Woods, Secretary of Health & Human Resources

Senate of Virginia
Senator William C. Mims

Virginia House of Delegates
Delegate Phillip Hamilton

Office of the Executive Secretary of the Virginia Supreme Court
Lelia Hopper, Director, Court Improvement

Local Government
B. David Canada, City Manager, City of Petersburg
Woodrow Harris, Councilman, City of Emporia

Parent
Brenda Sookins Wright

Private Provider
Greg Peters, Virginia Coalition of Private Provider Association

CSA State and Local Advisory Team
James Howard, Chair

Virginia Department of Education
JoLynne DeMary, Superintendent of Instruction
(Douglas Cox, Assistant Superintendent of Instruction)

Virginia Department of Health
Robert Stroube, Commissioner

Virginia Department of Juvenile Justice
Barry Green, Director
(Tim Howard, Deputy Director for Community Programs)

Virginia Department of Medical Assistance Services
Patrick Finnerty, Director
(Cynthia Jones, Deputy Director)

Virginia Department of Mental Health & Mental Retardation & Substance Abuse Services
James S. Reinhard, Commissioner
(Raymond Ratke, Chief Deputy)

Virginia Department of Social Services
Anthony Conyers, Jr., Commissioner
(Vickie Johnson-Scott, Director of Family Services

State and Local Structure
Comprehensive Services Act for At Risk Youth & Families

The CSA System is comprised of several entities at the state and community levels that work collaboratively to implement CSA.

State CSA Structure

The **State Executive Council** *(SEC)* is the statutorily based supervisory council that provides leadership and oversees the development and implementation of state interagency program and fiscal policies. Its mission is to direct a cost-effective collaborative system of services for youths that is child centered, family focused and community based. *(§2.2-2648)*

The **Office of Comprehensive Services** for At Risk Youth & Families *(OCS)* serves as the administrative entity of the SEC and ensures that its decisions are implemented. It works collaboratively with all CSA stakeholders to increase the capacity of communities across the Commonwealth to successfully implement CSA. *(§2.2-2649)*

The **State and Local Advisory Team** *(SLAT)* is statutorily required to advise the SEC by managing cooperative efforts at the state level and to provide support to community efforts. It works collaboratively with OCS to recommend interagency program and fiscal policies, assess the impact of proposed policies, regulations and guidelines; and provide best practices, training and technical assistance. It operationalizes SEC decisions in the respective agencies and associations. *(§2.2-5202 - §2.2-5203)*

Community CSA Structure

In each community, teams of professionals and family members collaboratively decide how to provide services and funding for children and their families.

The **Community Policy and Management Teams** *(CPMTs)* have the statutory authority and accountability for managing the cooperative effort and developing interagency policies that govern CSA in the community. They coordinate the locality's long-range, community-wide planning that ensures the development of needed resources and services. CPMTs are comprised of a parent, local government official, agency heads from local child serving agencies *(community services boards, courts service units, health, social services, and public schools)* and a private provider. Community agency representatives are authorized to make policy and funding decisions for their agencies. *(§2.2-5204 - §2.2-5206)*

The **Family Assessment and Planning Teams** *(FAPTs)* are established by CPMTs to provide for family participation, assess the strengths and needs of children and their families, develop individual family services plans, and make recommendations to the CPMTs. It is comprised of a parent and representatives from local child serving agencies *(community services boards, courts service units, social services, and public schools).* It may include a local health department and private provider representatives. *(§2.2-5207 - §2.2-5210)*

CSA Coordinators are hired by many, but not all, communities to manage local CSA implementation, including program, fiscal, and administrative responsibilities. *(Appropriations Act, Item 200.C.3)*

Web Links to Additional Comprehensive Services Act *(CSA)* Information

I. **Code Of Virginia Sections Related To The Comprehensive Services Act**
http://www.csa.virginia.gov/html/code/code.cfm

II. **CSA Background**
http://www.csa.virginia.gov/html/about/about.cfm

III. **State Executive Council Membership and Meeting Minutes**
http://www.csa.virginia.gov/html/council/agencymain.cfm

IV. **State and Local Advisory Team Membership and Meeting Minutes**
http://www.csa.virginia.gov/html/slat/slat.cfm

V. **Local CSA Contacts**
http://www.csa.virginia.gov/rosters/index.cfm

VI. **Statewide and Locality Specific Expenditures and Service Demographics**
http://www.csa.virginia.gov/html/statistics/stats.cfm

VII. **CSA Publications and Studies**
http://www.csa.virginia.gov/html/forms/pubs.cfm

VIII. **Provider Service Fee Directory**
http://www.csa.virginia.gov/sfd/defaultsfd.cfm

Description of CSA Services and Percent of All CSA Services Provided*
Comprehensive Services Act for At Risk Youth & Families

*Most communities do not have access to a full continuum of services locally or regionally.

Community Services *(28% of all CSA services provided).* Children received services in their homes or communities from private and public providers. Services may have included:

- Assessment and diagnostic testing
- Parent education and training
- Family support services
- Mentoring
- Behavioral aides
- School based services
- Respite care
- Crisis intervention & stabilization
- Outpatient individual & family therapy
- Substance abuse services
- Medication management
- Outpatient psychiatric visits
- Individualized wrap around services
- Intensive in-home services
- Functional family therapy
- Multisystemic therapy

Family Foster Home *(25%).* Children were placed in family homes with foster parents.

- Foster families received basic maintenance payments for room & board *(8% of CSA services).*
- Foster families provided additional services for the children *(14%).*
- Foster families received additional service payment for difficult children, but are not part of a therapeutic program *(3%).*

Therapeutic Foster Home *(12%).* Children were placed in family homes with trained foster parents who provided specialized care through a licensed child-placing agency or a local agency's foster care therapeutic program. Foster parents may have received additional payment for the added daily supervision required for children with emotional, behavioral, developmental, physical or mental disabilities.

Independent Living *(2%).* Older children in the custody of local social services or licensed child-placing agency. They are placed by the agency with court involvement in a living arrangement without daily supervision.

Services in Public Schools *(5%).* Children received services in the public school that were necessary to prevent more expensive and restrictive educational placements.

Special Education Private Day Placement *(9%).* Children received educational and related services through an approved educational program at a private day school.

Group Home *(7%).* Children were placed in licensed residential programs that provided supervision in homelike environments for groups of children with behavioral, emotional, physical and/or mental disabilities. Homes may have provided services such as social and life skills training, vocational training, or emergency placements.

Residential Treatment Facility *(12%).* Children were placed in licensed residential care facilities *(ie, secure residential facilities and campus-style residential programs).* The facility provided 24-hour supervised care and intensive treatment services, such as medication management, nursing care, special and regular education services, social skills training, therapy.

Psychiatric Hospital *(less than 1%).* Children were placed in acute care psychiatric units of licensed medical hospitals or free-standing psychiatric hospitals to stabilize harmful behaviors to self or others and/or to stabilize mental health issues *(e.g., psychosis).*

Comprehensive Services Act *(Agency 200)*
Funds in the Appropriations Act
FY2004 through 2006

	General Fund	Non-General Fund*	Total
FY 2004 (State Year)			
Pool Fund	$152,421,161	$9,419,998	$161,841,159
Medicaid	13,687,527	27,485,530	41,173,057
Local Administrative Funds	1,500,000	0	1,500,000
Utilization Review, Training, Web Services	285,182	0	285,182
Total, Chapter 29 FY2004	**$167,893,870**	**$36,905,528**	**$204,799,398**
FY 2005 (State Year)			
Pool Fund	$153,733,721	$9,419,998	$163,153,719
Medicaid	31,166,268	46,536,818	77,703,086
Local Administrative Funds	1,500,000	0	1,500,000
Utilization Review, Training, Web Services	295,000	0	295,000
Total, Chapter 951 FY2005	**$186,694,989**	**$55,956,816**	**$242,651,805**
FY 2006 (State Year)			
Pool Fund	$158,010,238	$9,419,998	$167,430,236
Medicaid	34,834,425	51,991,680	86,826,105
Local Administrative Funds	1,500,000	0	1,500,000
Utilization Review, Training, Web Services	295,000	0	295,000
Total, Chapter 951 FY2006	**$194,639,663**	**$61,411,678**	**$256,051,341**

*Includes Social Services Block Grant, TANF and Medicaid federal funds

CSA Expenditures and Census by Locality
FY 2005 and FY 2004
Source: Office of Comprehensive Services

Appendix F

FIPS	Locality	FY05 Pool Expenditures	FY05 State Expenditures	FY05 Local Expenditures	FY05 Census		FY04 Pool Expenditures	FY04 State Expenditures	FY04 Local Expenditures	FY04 Census
1	Accomack	1,805,892	1,384,758	421,134	75		1,348,383	1,033,940	314,443	65
3	Albemarle	5,780,218	3,194,148	2,586,070	268		5,062,829	2,797,719	2,265,110	241
5	Alleghany	619,539	500,340	119,199	30		744,467	601,232	143,235	24
7	Amelia	136,113	91,631	44,482	19		256,175	172,457	83,718	17
9	Amherst	619,163	450,627	168,536	61		488,442	355,488	132,954	60
11	Appomattox	230,789	169,884	60,905	33		90,783	66,825	23,958	13
13	Arlington	8,671,819	4,681,048	3,990,771	306		8,007,789	4,322,605	3,685,184	294
15	Augusta	2,249,289	1,506,574	742,715	205		2,007,842	1,344,853	662,989	165
17	Bath	60,545	34,644	25,901	7		93,546	53,527	40,019	8
19	Bedford County	2,900,032	1,925,621	974,411	183		2,518,084	1,672,008	846,076	164
21	Bland	119,201	94,062	25,139	15		78,556	61,989	16,567	17
23	Botetourt	1,258,174	804,980	453,194	61		1,076,617	688,820	387,797	66
25	Brunswick	267,717	202,421	65,296	22		401,877	303,859	98,018	27
27	Buchanan	731,159	500,405	230,754	97		610,460	417,799	192,661	95
29	Buckingham	778,992	621,402	157,590	48		644,800	514,357	130,443	45
31	Campbell	2,234,244	1,540,064	694,180	186		2,361,835	1,628,013	733,822	191
33	Caroline	539,727	361,185	178,542	30		465,972	311,828	154,144	28
35	Carroll	459,703	325,929	133,774	56		332,434	235,696	96,738	36
36	Charles City	123,592	84,895	38,697	11		334,662	229,879	104,783	15
37	Charlotte	343,516	267,805	75,711	37		415,241	323,722	91,519	37
41	Chesterfield	6,908,646	4,246,745	2,661,901	279		6,618,588	4,068,446	2,550,142	175
43	Clarke	800,440	416,469	383,971	33		742,039	386,083	355,956	37
45	Craig	53,860	38,235	15,625	15		151,695	107,688	44,007	11
47	Culpepper	1,360,798	848,185	512,613	123		1,355,066	844,613	510,453	110
49	Cumberland	703,196	489,424	213,772	52		636,312	442,873	193,439	39
51	Dickenson	745,239	518,537	226,702	119		695,096	483,648	211,448	122

CSA Expenditures and Census by Locality

Program Year 2005 and 2004

FIPS	Locality	FY05 Pool Expenditures	FY05 State Expenditures	FY05 Local Expenditures	FY05 Census		FY04 Pool Expenditures	FY04 State Expenditures	FY04 Local Expenditures	FY04 Census
53	Dinwiddie	511,876	339,988	171,888	41		323,239	214,695	108,544	34
57	Essex	685,558	421,413	264,145	29		535,147	328,955	206,192	25
61	Fauquier	2,029,470	1,099,161	930,309	136		1,865,608	1,010,413	855,195	118
63	Floyd	623,877	478,888	144,989	21		554,098	425,326	128,772	23
65	Fluvanna	1,658,939	1,026,717	632,222	101		1,312,457	812,280	500,177	71
67	Franklin County	2,616,873	1,876,298	740,575	177		2,578,191	1,848,563	729,628	167
69	Frederick	1,985,295	1,122,089	863,206	89		2,209,709	1,248,927	960,782	76
71	Giles	372,463	264,523	107,940	40		302,881	215,106	87,775	30
73	Gloucester	653,024	412,254	240,770	40		521,926	329,492	192,434	44
75	Goochland	920,383	472,064	448,319	39		953,154	488,873	464,281	36
77	Grayson	659,942	520,760	139,182	51		1,131,335	892,736	238,599	103
79	Greene	1,179,928	770,375	409,553	56		743,377	485,351	258,026	46
83	Halifax	1,285,512	985,345	300,167	71		1,222,692	937,193	285,499	86
85	Hanover	3,466,230	1,925,837	1,540,393	118		3,715,179	2,064,153	1,651,026	126
87	Henrico	6,050,208	3,778,355	2,271,853	301		5,606,059	3,500,984	2,105,075	289
89	Henry	632,196	456,066	176,130	118		707,482	510,378	197,104	137
91	Highland	27,976	17,284	10,692	2		138,309	85,447	52,862	2
93	Isle of Wight	128,118	81,829	46,289	23		181,574	115,971	65,603	25
95	James City	144,269	79,593	64,676	16		111,903	61,737	50,166	12
97	King & Queen	188,207	129,035	59,172	13		207,382	142,181	65,201	11
99	King George	825,960	526,384	299,576	44		682,088	434,695	247,393	34
101	King William	482,351	296,501	185,850	25		377,698	232,171	145,527	24
103	Lancaster	411,002	230,531	180,471	20		179,275	100,555	78,720	15
105	Lee	872,915	676,946	195,969	80		719,387	557,885	161,502	83
107	Loudoun	5,371,638	2,812,590	2,559,048	212		5,536,465	2,898,893	2,637,572	189
109	Louisa	895,449	501,362	394,087	56		680,087	380,781	299,306	41
111	Lunenburg	358,074	297,273	60,801	24		299,003	248,232	50,771	25
113	Madison	143,563	95,398	48,165	19		193,393	128,510	64,883	18

CSA Expenditures and Census by Locality										
Program Year 2005 and 2004										
FIPS	Locality	FY05 Pool Expenditures	FY05 State Expenditures	FY05 Local Expenditures	FY05 Census		FY04 Pool Expenditures	FY04 State Expenditures	FY04 Local Expenditures	FY04 Census
115	Mathews	346,777	198,669	148,108	22		270,281	154,844	115,437	13
117	Mecklenburg	1,336,786	1,031,197	305,589	91		1,047,942	808,382	239,560	85
119	Middlesex	248,198	140,654	107,544	25		149,341	84,632	64,709	19
121	Montgomery	1,943,570	1,392,762	550,808	87		1,695,036	1,214,663	480,373	85
125	Nelson	510,939	350,913	160,026	25		517,056	355,114	161,942	16
127	New Kent	924,586	524,333	400,253	31		816,185	462,859	353,326	30
131	Northampton	788,173	632,824	155,349	43		634,487	509,430	125,057	49
133	Northumberland	215,598	144,364	71,234	22		160,614	107,547	53,067	22
135	Nottoway	376,090	275,072	101,018	14		124,416	90,998	33,418	12
137	Orange	638,631	377,878	260,753	68		767,440	454,094	313,346	67
139	Page	1,682,853	1,200,716	482,137	99		1,003,770	716,190	287,580	81
141	Patrick	213,449	159,254	54,195	39		289,646	216,105	73,541	52
143	Pittsylvania	3,288,448	2,514,018	774,430	160		2,563,361	1,959,689	603,672	115
145	Powhatan	1,051,006	594,659	456,347	32		1,102,986	624,069	478,917	36
147	Prince Edward	1,056,371	820,589	235,782	58		454,656	354,449	100,207	47
149	Prince George	362,952	228,079	134,873	40		320,623	201,479	119,144	49
153	Prince William	6,400,636	4,215,459	2,185,177	390		6,043,735	3,980,404	2,063,331	358
155	Pulaski	2,530,412	1,790,773	739,639	150		2,748,258	1,944,942	803,316	130
157	Rappahannock	236,066	136,942	99,124	22		160,885	93,329	67,556	20
159	Richmond County	248,725	168,461	80,264	10		230,466	156,095	74,371	9
161	Roanoke County	4,575,361	2,563,575	2,011,786	182		3,730,003	2,089,921	1,640,082	134
163	Rockbridge	1,087,383	833,370	254,013	52		789,154	604,808	184,346	33
165	Rockingham	3,602,664	2,361,546	1,241,118	169		3,160,419	2,071,655	1,088,764	139
167	Russell	642,765	521,025	121,740	75		928,621	752,740	175,881	78
169	Scott	283,416	194,027	89,389	67		293,245	200,756	92,489	53
171	Shenandoah	1,498,621	971,556	527,065	93		1,159,510	751,710	407,800	67
173	Smyth	726,086	556,400	169,686	139		650,232	498,273	151,959	99
175	Southampton	29,769	20,154	9,615	5		49,431	33,465	15,966	8

CSA Expenditures and Census by Locality

Program Year 2005 and 2004

FIPS	Locality	FY05 Pool Expenditures	FY05 State Expenditures	FY05 Local Expenditures	FY05 Census		FY04 Pool Expenditures	FY04 State Expenditures	FY04 Local Expenditures	FY04 Census
177	Spotsylvania	4,656,774	2,520,246	2,136,528	209		5,168,585	2,797,238	2,371,347	193
179	Stafford	3,270,787	1,818,885	1,451,902	152		3,214,156	1,787,392	1,426,764	157
181	Surry	89,175	53,692	35,483	11		19,053	11,472	7,581	8
183	Sussex	617,437	470,055	147,382	38		225,543	171,706	53,837	19
185	Tazewell	1,704,276	1,285,876	418,400	168		1,677,331	1,265,546	411,785	139
187	Warren	2,220,051	1,364,665	855,386	87		1,950,864	1,199,196	751,668	73
191	Washington	747,264	541,019	206,245	106		635,417	460,042	175,375	91
193	Westmoreland	885,344	617,527	267,817	37		659,801	460,211	199,590	40
195	Wise	277,730	201,215	76,515	98		278,509	201,780	76,729	75
197	Wythe	827,094	603,117	223,977	69		901,139	657,111	244,028	73
199	York	849,774	519,382	330,392	39		614,087	375,330	238,757	32
510	Alexandria	8,355,991	3,919,795	4,436,196	399		7,415,336	3,478,534	3,936,802	368
515	Bedford City	430,700	320,872	109,829	33		496,745	370,075	126,670	32
520	Bristol	860,214	641,117	219,097	105		739,574	551,205	188,369	79
530	Buena Vista	279,827	214,655	65,172	17		258,893	198,597	60,296	14
540	Charlottesville	6,430,301	4,457,485	1,972,816	317		6,686,145	4,634,836	2,051,309	313
550	Chesapeake	3,337,495	2,097,616	1,239,879	242		3,020,011	1,898,077	1,121,934	212
570	Colonial Heights	404,109	241,374	162,735	21		278,315	166,238	112,077	14
580	Covington	752,714	564,837	187,877	31		500,523	375,592	124,931	21
590	Danville	2,201,011	1,711,726	489,285	180		2,414,091	1,877,439	536,652	130
620	Franklin City	179,182	112,705	66,477	12		122,370	76,971	45,399	10
630	Fredericksburg	1,194,811	783,677	411,134	66		940,591	616,934	323,657	69
640	Galax	147,499	101,096	46,403	29		128,740	88,238	40,502	27
650	Hampton	3,570,767	2,419,909	1,150,858	378		4,129,236	2,798,383	1,330,853	369
660	Harrisonburg	2,651,874	1,642,040	1,009,834	131		2,148,854	1,330,570	818,284	132
670	Hopewell	1,979,734	1,451,739	527,995	84		1,962,162	1,438,853	523,309	69
678	Lexington	307,922	206,246	101,676	8		306,338	205,185	101,153	6
680	Lynchburg	3,679,958	2,673,121	1,006,837	321		4,245,459	3,083,901	1,161,558	312

CSA Expenditures and Census by Locality										
Program Year 2005 and 2004										
FIPS	Locality	FY05 Pool Expenditures	FY05 State Expenditures	FY05 Local Expenditures	FY05 Census		FY04 Pool Expenditures	FY04 State Expenditures	FY04 Local Expenditures	FY04 Census
683	Manassas City	1,492,560	870,461	622,099	54		1,564,277	912,286	651,991	64
685	Manassas Park	1,371,930	785,704	586,226	31		514,464	294,634	219,830	17
690	Martinsville	141,434	94,464	46,970	60		253,709	169,452	84,257	61
700	Newport News	12,730,065	9,200,018	3,530,047	654		13,904,978	10,049,128	3,855,850	664
710	Norfolk	10,475,984	7,904,130	2,571,854	1,571		8,246,905	6,222,290	2,024,615	773
720	Norton	19,631	13,243	6,388	7		11,147	7,520	3,627	5
730	Petersburg	3,302,462	2,135,042	1,167,420	161		3,028,109	1,957,672	1,070,437	179
735	Poquoson	388,155	279,976	108,179	14		226,908	163,669	63,239	11
740	Portsmouth	3,498,061	2,586,816	911,245	259		2,933,162	2,169,073	764,089	267
750	Radford	409,953	326,528	83,425	24		530,150	422,264	107,886	21
760	Richmond City	17,168,675	10,831,717	6,336,958	736		17,599,317	11,103,409	6,495,908	803
770	Roanoke City	9,433,474	6,535,511	2,897,963	554		9,298,438	6,441,958	2,856,480	553
775	Salem	917,054	594,893	322,161	48		561,437	364,204	197,233	29
790	Staunton	1,660,358	1,212,227	448,131	146		1,566,761	1,143,892	422,869	130
800	Suffolk	982,487	743,546	238,941	115		920,490	696,627	223,863	130
810	Virginia Beach	8,460,207	5,440,759	3,019,448	651		7,634,533	4,909,768	2,724,765	591
820	Waynesboro	879,457	541,482	337,975	118		904,833	557,106	347,727	92
830	Williamsburg	47,648	25,954	21,694	13		50,423	27,465	22,958	15
840	Winchester	2,083,235	1,127,655	955,580	80		2,204,941	1,193,535	1,011,406	81
1200	Greensville/Emporia	460,393	356,068	104,325	37		488,694	377,956	110,738	39
1300	Fairfax/Falls Church	31,809,471	17,142,124	14,667,347	1,008		32,751,403	17,649,731	15,101,672	1,090
	Totals	273,171,739	174,218,155	98,953,584	16,272		259,323,434	165,073,380	94,250,054	14,590

Historical Statewide Summary of CSA Census and Expenditures
Program Years 1994-2005
Source: Office of Comprehensive Services as reported by local governments

Appendix G

	1994		1995		1996		1997	
	# Youth	Expend.	# Youth	Expend.	# Youth	Expend.	# Youth	Expend.
Mandated								
Residential	6,878	$76,608,685	7,989	$86,829,224	8,993	$102,353,408	10,511	$115,196,207
Non-Residential	2,603	$17,933,661	3,873	$29,529,446	4,455	$32,253,731.00	4,820	$32,949,335
Total Mandated		**$94,542,346**		**$116,358,670**		**$134,607,139**		**$148,145,542**
% Change from Prior Year		N/A		23.08%		15.68%		10.06%
Non-Mandated								
Residential	355	$8,062,627	349	$6,487,856	454	$6,537,360	384	$5,607,693
Non-Residential	662	$1,949,912	875	$2,801,537	1,007	$2,853,933	1,459	$3,145,982
Total Non-Mandated		**$10,012,539**		**$9,289,393**		**$9,391,293**		**$8,753,675**
% Change from Prior Year		N/A		-7.22%		1.10%		-6.79%
Totals		**$104,554,885**		**$125,648,063**		**$143,998,432**		**$156,899,217**
% Change from Prior Year		N/A		20.17%		14.60%		8.96%
State Share		$63,946,912		$77,914,556		$90,054,280		$98,654,903
Local Share		$40,607,978		$47,733,505		$53,944,153		$58,244,310
Local Share %		38.84%		37.99%		37.46%		37.12%
Unduplicated Census	**10,214**		**12,028**		**13,235**		**14,282**	
% Change from Prior Year	N/A		17.76%		10.03%		7.91%	
Unit Cost		**$10,236**		**$10,446**		**$10,880**		**$10,986**
% Change from Prior Year		N/A		2.05%		4.15%		0.97%

	1998		1999		2000		2001	
	# Youth	Expend.	# Youth	Expend.	# Youth	Expend.	# Youth	Expend.
Mandated								
Foster Care IV-E - Residential	1,651	$28,658,220	1,945	$31,649,468	1,829	$31,623,816	1,714	$23,717,657
Foster Care - Others - Residential	2,641	$55,358,986	2,876	$65,722,955	3,001	$67,436,878	3,150	$65,466,646
Family Foster Care IV-E	1,968	$4,693,755	1,937	$4,870,482	1,849	$4,929,056	1,678	$4,537,488
Family Foster Care - Maintenance	n/a	n/a	3,021	$5,172,056	3,057	$5,079,928	3,241	$5,350,897
Family Foster Care - Others	4,783	$12,094,700	2,646	$8,387,204	2,616	$7,843,686	3,045	$9,600,734
Foster Care Prevention - Residential	330	$3,944,756	428	$6,333,702	476	$6,778,142	350	$4,008,532
Special Education - Residential	596	$25,650,682	650	$25,875,762	726	$28,780,560	753	$28,591,439
Foster Care Prevention - Non-Residential	2,235	$7,143,447	2,216	$9,032,565	2,299	$9,046,630	2,137	$7,817,209
Special Education - Private Day	1,594	$24,943,816	1,531	$24,579,841	1,685	$28,156,477	1,764	$31,632,292
Special Education - Other Day	414	$2,877,716	609	$4,423,563	786	$5,013,580	883	$6,085,784
Total Mandated		**$165,366,078**				**$194,688,752**		**$186,808,678**
% Change from Prior Year		11.62%		12.51%		4.64%		-4.05%
Non-Mandated								
Residential	266	$5,450,505	390	$7,330,757	298	$6,586,767	293	$5,754,901
Non-Residential	1,185	$3,649,918	1,213	$3,394,448	1,140	$3,395,279	1,038	$2,970,408
Total Non-Mandated		**$9,100,423**		**$10,725,205**		**$9,982,046**		**$8,725,309**
% Change from Prior Year		3.96%		17.85%		-6.93%		-12.59%
Totals		**$174,466,501**				**$204,670,798**		**$195,533,986**
% Change from Prior Year		11.20%		12.79%		4.01%		-4.46%
State Share		$110,741,584		$124,596,500		$129,515,681		$123,208,287
Local Share		$63,724,916		$72,176,241		$75,155,117		$72,325,699
Local %		36.53%		36.68%		36.72%		36.99%
Unduplicated Census	**14,359**		**14,680**		**14,757**		**14,700**	
% Change from Prior Year	0.54%		2.24%		0.52%		-0.39%	
Unit Cost		**$12,150**		**$13,404**		**$13,869**		**$13,302**
% Change from Prior Year		10.60%		10.32%		3.47%		-4.09%

	2002		2003		2004		2005	
	#	Expend.	# Youth	Expend.	# Youth	Expend.	# Youth	Expend.
Mandated								
Foster Care IV-E - Residential	2,097	$31,362,412	2,397	$41,355,566	2,039	$41,713,897	2,301	$41,148,412
Foster Care - Others - Residential	3,368	$75,992,070	3,168	$70,761,993	2,837	$83,574,134	2,926	$88,214,751
Family Foster Care IV-E	1,724	$5,539,932	1,980	$7,857,040	888	$8,613,214	1,164	$7,748,227
Family Foster Care - Maintenance	2,909	$5,532,068	2,587	$4,929,412	1,425	$4,929,990	1,931	$3,836,557
Family Foster Care - Others	2,972	$11,256,651	2,766	$11,438,206	1,391	$13,507,503	892	$14,400,994
Foster Care Prevention - Residential	304	$4,394,411	245	$4,680,531	273	$4,863,347	400	$6,694,305
Special Education - Residential	790	$32,626,726	842	$32,400,123	686	$34,296,833	758	$34,799,092
Foster Care Prevention - NonResidential	2,184	$9,369,239	2,118	$7,664,338	2,136	$8,726,496	3,004	$9,398,199
Special Education - Private Day	2,015	$35,682,344	1,967	$37,834,777	1,873	$40,590,558	1,944	$46,289,598
Special Education - Other Day	912	$7,369,747	1,028	$8,590,090	1,100	$9,526,320	1,306	$11,130,484
Total Mandated				**$227,512,076**		**$250,465,126**		**$263,660,618**
% Change from Prior Year		17.30%		3.83%		10.09%		5.27%
Non-Mandated								
Residential	328	$5,575,521	348	$4,801,605	147	$5,011,928	319	$5,493,935
Non-Residential	929	$3,112,171	1,144	$3,202,374	879	$3,969,215	860	$4,017,122
Total Non-Mandated		**$8,687,691**		**$8,003,980**		**$8,981,143**		**$9,511,058**
% Change from Prior Year		-0.43%		-7.87%		12.21%		5.90%
Totals				**$235,516,055**		**$259,513,411**		**$273,171,676**
% Change from Prior Year		16.51%		3.38%		10.19%		5.26%
State Share				$149,551,129		$165,262,086		$178,920,350
Local Share		$83,360,034		$85,964,926		$94,251,325		$94,251,326
Local %		36.59%		36.50%		36.32%		34.50%
Unduplicated Census	**14,889**		**15,564**		**14,580**		**16,272**	
% Change from Prior Year	1.29%		4.53%		-6.32%		11.60%	
Unit Cost		**$15,301**		**$15,132**		**$17,799**		**$16,788**
% Change from Prior Year		15.03%		-1.10%		17.63%		-5.68%

FY 2005 Number of Children in Residential Care* By Locality **Appendix H**

Source: Office of Comprehensive Services

FIPS	LOCALITY	FY05 RESIDENTIAL CHILD COUNT	TOTAL FY05 CHILD COUNT	% OF LOCAL CASES THAT ARE RESIDENTIAL
1	Accomack	30	75	40.00
3	Albemarle	70	268	26.12
5	Alleghany	12	30	40.00
7	Amelia	2	19	10.53
9	Amherst	15	61	24.59
11	Appomattox	6	33	18.18
13	Arlington	80	306	26.14
15	Augusta	50	205	24.39
17	Bath	4	7	57.14
19	Bedford County	59	183	32.24
21	Bland	6	15	40.00
23	Botetourt	10	61	16.39
25	Brunswick	5	22	22.73
27	Buchanan	30	97	30.93
29	Buckingham	11	48	22.92
31	Campbell	22	186	11.83
33	Caroline	7	30	23.33
35	Carroll	13	56	23.21
36	Charles City	1	11	9.09
37	Charlotte	3	37	8.11
41	Chesterfield	97	279	34.77
43	Clarke	8	33	24.24
45	Craig	2	15	13.33
47	Culpeper	25	123	20.33
49	Cumberland	10	52	19.23
51	Dickenson	16	119	13.45
53	Dinwiddie	9	41	21.95
57	Essex	10	29	34.48
61	Fauquier	27	136	19.85
63	Floyd	11	21	52.38
65	Fluvanna	29	101	28.71
67	Franklin County	44	177	24.86
69	Frederick	20	89	22.47
71	Giles	11	40	27.50
73	Gloucester	11	40	27.50
75	Goochland	9	39	23.08
77	Grayson	10	51	19.61
79	Greene	26	56	46.43
83	Halifax	23	71	32.39
85	Hanover	32	118	27.12
87	Henrico	95	301	31.56
89	Henry	10	118	8.47
91	Highland	1	2	50.00
93	Isle of Wight	7	23	30.43
95	James City	4	16	25.00
97	King & Queen	0	13	0.00
99	King George	17	44	38.64

*Residential Care: group homes, residential treatment facilities, psychiatric hospitals

FY 2005 Number of Children in Residential Care By Locality

FIPS	LOCALITY	FY05 RESIDENTIAL CHILD COUNT	TOTAL FY05 CHILD COUNT	% OF LOCAL CASES THAT ARE RESIDENTIAL
101	King William	6	25	24.00
103	Lancaster	6	20	30.00
105	Lee	29	80	36.25
107	Loudoun	42	212	19.81
109	Louisa	24	56	42.86
111	Lunenburg	4	24	16.67
113	Madison	11	19	57.89
115	Mathews	5	22	22.73
117	Mecklenburg	24	91	26.37
119	Middlesex	1	25	4.00
121	Montgomery	31	87	35.63
125	Nelson	6	25	24.00
127	New Kent	12	31	38.71
131	Northampton	6	43	13.95
133	Northumberland	4	22	18.18
135	Nottoway	4	14	28.57
137	Orange	6	68	8.82
139	Page	22	99	22.22
141	Patrick	9	39	23.08
143	Pittsylvania	29	160	18.13
145	Powhatan	9	32	28.13
147	Prince Edward	18	58	31.03
149	Prince George	4	40	10.00
153	Prince William	145	390	37.18
155	Pulaski	48	150	32.00
157	Rappahannock	4	22	18.18
159	Richmond County	4	10	40.00
161	Roanoke County	57	182	31.32
163	Rockbridge	23	52	44.23
165	Rockingham	56	169	33.14
167	Russell	27	75	36.00
169	Scott	21	67	31.34
171	Shenandoah	29	93	31.18
173	Smyth	27	139	19.42
175	Southampton	0	5	0.00
177	Spotsylvania	52	209	24.88
179	Stafford	45	152	29.61
181	Surry	0	11	0.00
183	Sussex	4	38	10.53
185	Tazewell	35	168	20.83
187	Warren	32	87	36.78
191	Washington	12	106	11.32
193	Westmoreland	6	37	16.22
195	Wise	11	98	11.22
197	Wythe	15	69	21.74
199	York	7	39	17.95
510	Alexandria	68	399	17.04
515	Bedford City	13	33	39.39
520	Bristol	25	105	23.81

*Residential Care: group homes, residential treatment facilities, psychiatric hospitals

FY 2005 Number of Children in Residential Care By Locality

FIPS	LOCALITY	FY05 RESIDENTIAL CHILD COUNT	TOTAL FY05 CHILD COUNT	% OF LOCAL CASES THAT ARE RESIDENTIAL
530	Buena Vista	5	17	29.41
540	Charlottesville	112	317	35.33
550	Chesapeake	58	242	23.97
570	Colonial Heights	7	21	33.33
580	Covington	18	31	58.06
590	Danville	33	180	18.33
620	Franklin City	3	12	25.00
630	Fredericksburg	15	66	22.73
640	Galax	2	29	6.90
650	Hampton	36	378	9.52
660	Harrisonburg	43	131	32.82
670	Hopewell	21	84	25.00
678	Lexington	4	8	50.00
680	Lynchburg	29	321	9.03
683	Manassas City	17	54	31.48
685	Manassas Park	14	31	45.16
690	Martinsville	4	60	6.67
700	Newport News	136	654	20.80
710	Norfolk	264	1,571	16.80
720	Norton	0	7	0.00
730	Petersburg	52	161	32.30
735	Poquoson	0	14	0.00
740	Portsmouth	37	259	14.29
750	Radford	7	24	29.17
760	Richmond City	321	736	43.61
770	Roanoke City	111	554	20.04
775	Salem	24	48	50.00
790	Staunton	28	146	19.18
800	Suffolk	23	115	20.00
810	Virginia Beach	194	651	29.80
820	Waynesboro	14	118	11.86
830	Williamsburg	5	13	38.46
840	Winchester	27	80	33.75
1200	Greensville/Emporia	5	37	13.51
1300	Fairfax/Falls Church	299	1,008	29.66
	Statewide Totals	**4,046**	**16,272**	**24.86**

*Residential Care: group homes, residential treatment facilities, psychiatric hospitals

FY 2005 Residential Care* Expenditures By Locality

Appendix I

Source: Office of Comprehensive Services

FIPS	Locality	FY05 Total Pool Expenditures	FY05 Total Residential Expenditures	FY05 Percent of Locality Total Expenditures That Are Residential
1	Accomack	1,805,892	1,208,549	66.92%
3	Albemarle	5,780,218	3,124,395	54.05%
5	Alleghany	619,539	439,881	71.00%
7	Amelia	136,113	36,383	26.73%
9	Amherst	619,163	202,025	32.63%
11	Appomattox	230,789	66,111	28.65%
13	Arlington	8,671,819	3,856,463	44.47%
15	Augusta	2,249,289	1,157,734	51.47%
17	Bath	60,545	22,588	37.31%
19	Bedford County	2,900,032	1,767,850	60.96%
21	Bland	119,201	25,717	21.57%
23	Botetourt	1,258,174	391,434	31.11%
25	Brunswick	267,717	76,730	28.66%
27	Buchanan	731,159	557,165	76.20%
29	Buckingham	778,992	246,286	31.62%
31	Campbell	2,234,244	706,522	31.62%
33	Caroline	539,727	86,679	16.06%
35	Carroll	459,703	341,821	74.36%
36	Charles City	123,592	4,069	3.29%
37	Charlotte	343,516	29,761	8.66%
41	Chesterfield	6,908,646	3,465,002	50.15%
43	Clarke	800,440	481,798	60.19%
45	Craig	53,860	6,084	11.30%
47	Culpeper	1,360,798	771,713	56.71%
49	Cumberland	703,196	298,417	42.44%
51	Dickenson	745,239	324,010	43.48%
53	Dinwiddie	511,876	129,969	25.39%
57	Essex	685,558	426,701	62.24%
61	Fauquier	2,029,470	736,469	36.29%
63	Floyd	623,877	554,525	88.88%
65	Fluvanna	1,658,939	970,863	58.52%
67	Franklin County	2,616,873	1,266,259	48.39%
69	Frederick	1,985,295	1,267,943	63.87%
71	Giles	372,463	209,611	56.28%
73	Gloucester	653,024	419,371	64.22%
75	Goochland	920,383	275,047	29.88%
77	Grayson	659,942	200,146	30.33%
79	Greene	1,179,928	791,218	67.06%
83	Halifax	1,285,512	458,768	35.69%
85	Hanover	3,466,230	1,575,236	45.45%
87	Henrico	6,050,208	2,807,469	46.40%
89	Henry	632,196	260,792	41.25%
91	Highland	27,976	1,502	5.37%
93	Isle of Wight	128,118	48,512	37.87%

*Residential Care: group homes, residential treatment facilities, psychiatric hospitals

FY 2005 Residential Care Expenditures By Locality				
FIPS	Locality	FY05 Total Pool Expenditures	FY05 Total Residential Expenditures	FY05 Percent of Locality Total Expenditures That Are Residential
95	James City	144,269	72,914	50.54%
97	King & Queen	188,207	0	0.00%
99	King George	825,960	405,553	49.10%
101	King William	482,351	203,658	42.22%
103	Lancaster	411,002	261,343	63.59%
105	Lee	872,915	692,130	79.29%
107	Loudoun	5,371,638	1,819,627	33.87%
109	Louisa	895,449	757,692	84.62%
111	Lunenburg	358,074	120,647	33.69%
113	Madison	143,563	130,228	90.71%
115	Mathews	346,777	199,559	57.55%
117	Mecklenburg	1,336,786	855,092	63.97%
119	Middlesex	248,198	750	0.30%
121	Montgomery	1,943,570	1,472,417	75.76%
125	Nelson	510,939	217,609	42.59%
127	New Kent	924,586	273,135	29.54%
131	Northampton	788,173	347,469	44.09%
133	Northumberland	215,598	71,444	33.14%
135	Nottoway	376,090	344,235	91.53%
137	Orange	638,631	171,145	26.80%
139	Page	1,682,853	797,971	47.42%
141	Patrick	213,449	148,569	69.60%
143	Pittsylvania	3,288,448	1,079,938	32.84%
145	Powhatan	1,051,006	562,966	53.56%
147	Prince Edward	1,056,371	754,635	71.44%
149	Prince George	362,952	88,661	24.43%
153	Prince William	6,400,636	4,016,337	62.75%
155	Pulaski	2,530,412	1,210,727	47.85%
157	Rappahannock	236,066	113,455	48.06%
159	Richmond County	248,725	102,894	41.37%
161	Roanoke County	4,575,361	2,775,971	60.67%
163	Rockbridge	1,087,383	824,332	75.81%
165	Rockingham	3,602,664	2,389,092	66.31%
167	Russell	642,765	400,828	62.36%
169	Scott	283,416	150,001	52.93%
171	Shenandoah	1,498,621	765,336	51.07%
173	Smyth	726,086	474,678	65.37%
175	Southampton	29,769	0	0.00%
177	Spotsylvania	4,656,774	2,237,342	48.04%
179	Stafford	3,270,787	2,185,265	66.81%
181	Surry	89,175	0	0.00%
183	Sussex	617,437	23,380	3.79%
185	Tazewell	1,704,276	692,046	40.61%
187	Warren	2,220,051	1,411,053	63.56%

*Residential Care: group homes, residential treatment facilities, psychiatric hospitals

FY 2005 Residential Care Expenditures By Locality				
FIPS	Locality	FY05 Total Pool Expenditures	FY05 Total Residential Expenditures	FY05 Percent of Locality Total Expenditures That Are Residential
191	Washington	747,264	294,452	39.40%
193	Westmoreland	885,344	308,011	34.79%
195	Wise	277,730	82,715	29.78%
197	Wythe	827,094	414,172	50.08%
199	York	849,774	517,193	60.86%
510	Alexandria	8,355,991	2,591,118	31.01%
515	Bedford City	430,700	236,808	54.98%
520	Bristol	860,214	459,260	53.39%
530	Buena Vista	279,827	83,189	29.73%
540	Charlottesville	6,430,301	3,346,953	52.05%
550	Chesapeake	3,337,495	1,849,303	55.41%
570	Colonial Heights	404,109	61,390	15.19%
580	Covington	752,714	583,179	77.48%
590	Danville	2,201,011	695,677	31.61%
620	Franklin City	179,182	77,646	43.33%
630	Fredericksburg	1,194,811	622,159	52.07%
640	Galax	147,499	76,997	52.20%
650	Hampton	3,570,767	477,357	13.37%
660	Harrisonburg	2,651,874	1,429,862	53.92%
670	Hopewell	1,979,734	820,500	41.44%
678	Lexington	307,922	272,962	88.65%
680	Lynchburg	3,679,958	254,532	6.92%
683	Manassas City	1,492,560	913,761	61.22%
685	Manassas Park	1,371,930	975,406	71.10%
690	Martinsville	141,434	78,523	55.52%
700	Newport News	12,730,065	4,681,184	36.77%
710	Norfolk	10,475,984	4,764,120	45.48%
720	Norton	19,631	0	0.00%
730	Petersburg	3,302,462	1,505,981	45.60%
735	Poquoson	388,155	0	0.00%
740	Portsmouth	3,498,061	788,161	22.53%
750	Radford	409,953	276,540	67.46%
760	Richmond City	17,168,675	10,698,392	62.31%
770	Roanoke City	9,433,474	4,265,334	45.21%
775	Salem	917,054	732,882	79.92%
790	Staunton	1,660,358	863,307	52.00%
800	Suffolk	982,487	340,813	34.69%
810	Virginia Beach	8,460,207	4,720,013	55.79%
820	Waynesboro	879,457	357,263	40.62%
830	Williamsburg	47,648	23,423	49.16%
840	Winchester	2,083,235	1,305,105	62.65%
1200	Greensville/Emporia	460,393	115,148	25.01%
1300	Fairfax/Falls Church	31,809,471	16,425,100	51.64%
	Totals	***273,171,739***	***133,103,603****	*48.73%*

*Residential Care: group homes, residential treatment facilities, psychiatric hospitals
**Total does not include cost recoveries

Report of the Secretary of Health and Human Resources

A Plan for Improving Services and Containing Costs in the Treatment and Care of Children Under the Comprehensive Services act for At-Risk Youth and Families

October 15, 2002

Introduction

In 2002, the Virginia General Assembly passed budget language directing the Secretary of Health and Human Resources to develop and promptly implement a plan for improving services and containing costs in the treatment and care of children served through the Comprehensive Services Act (CSA). With the passage of CSA in 1992, the General Assembly altered the administrative and funding systems for providing services to at-risk youth and their families. Specifically, eight funding streams from five state agencies were combined to finance the program. The overarching goal of the program was to promote the treatment of emotionally disturbed children in the least restrictive environment through interagency collaboration at the both the State and local level.

This General Assembly's request for an action plan was prompted largely by concerns associated with the total general fund cost of the program (over $194 million in fiscal year 01), and the average rate at which these costs have been increasing (approximately 10 percent per year). In addition, while it is widely recognized that a number of the initial goals established for CSA have been realized, it has become equally apparent that problems exist with both the State and local management of the program. Accordingly, the budget language passed by the 2002 Virginia General Assembly directed the Secretary of Health and Human Resources to establish a plan that addresses the following issues:

- methods for evaluating and monitoring the quality, appropriateness, and outcomes of care;
- strategies for increasing federal reimbursements for the program;
- assessment and development of negotiated statewide contracts for services purchased by state and local agencies;
- revised allocation methodologies, reimbursement procedures, and cost-sharing formulas for localities;
- coordinated collection of information among state agencies;
- a review of the program's organization and management structure; and
- projections of caseloads, service needs, and costs.

By October 15, 2002, the Secretary is required to submit to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees all recommendations from this Action Plan that impact funding or require statutory revisions.

To develop this plan, the Secretary appointed a Steering Committee consisting of legislators, public and private stakeholders, and state and local partners. From this Committee, separate task groups were assembled and assigned the issues that provide the framework of the Action Plan. Each group examined the relevant CSA policies for their issue area and made recommendations to the Steering Committee for future action.

Appendix A details the Steering Committee's blueprint for action to reform key aspects of the program. As shown, some of the recommendations offered by the committee have been categorized as "near term" with a high priority status. These are essentially those recommendations that the Committee believes should be given immediate consideration by the Governor and the General Assembly. Some of these recommendations are designed to more closely match local allocations for CSA to actual program needs. Others focus on the organization and management of CSA. Also, as a means of defraying the general fund cost of the program, the Steering Committee has recommended expanding the use and scope of Medicaid coverage in CSA.

These and other near-term recommendations are discussed in more detail in the body of this Action Plan. This plan also discusses the longer-term recommendations that the Steering Committee believes require greater study before they can be implemented.

Report of the Secretary of Health and Human Resources

2003 PROGRESS REPORT

A Plan For Improving Services And Containing Costs In The Treatment And Care Of Children Under The Comprehensive Services Act For At-Risk Youth And Families

October 15, 2003

Introduction

With the passage of CSA in 1992, the General Assembly altered the administrative and funding systems for providing services to at-risk youth and their families. Specifically, eight funding streams from five state agencies were combined to finance the program. The overarching goal of the program was to promote the treatment of emotionally disturbed children in the least restrictive environment through interagency collaboration at the State and local levels.

Concerns associated with the total general fund cost of the program (over $194 million in fiscal year 01), and the average rate at which these costs have been increasing (approximately 10 percent per year) prompted the 2002 Virginia General Assembly to pass budget language directing the Secretary of Health and Human Resources to develop and implement a plan for improving services and containing costs in the treatment and care of children served through the Comprehensive Services Act (CSA).

To develop this plan, the Secretary appointed a Steering Committee consisting of legislators, public and private stakeholders, and state and local partners. From this Committee, separate task groups were assembled and assigned the key issues specified in the 2002 Budget (Item 298.D) that provided the framework of the Action Plan. Each group examined the relevant CSA policies for their issue area and made recommendations to the Steering Committee for future action.

The Steering Committee's 2002 report to the General Assembly and Governor contained a Blueprint for Change in CSA that summarized key aspects of the program earmarked for reform. To provide the progress report requested in the 2003 Budget (Item 298.D.2), we have examined and provided an update on each of those key reform areas. Additionally, the Blueprint for Change, located in the back of the progress report, has been updated and provides a quick overview of the progress on each recommendation.

The Revision of Allocation Methodologies, Reimbursement Procedures, and Cost Sharing Formulas for Localities

Statement of the Problem

In CSA, each locality receives an initial base allocation that has been found to account for only 55 percent of annualized costs. Additional funds are available through a supplemental funding process that requires local governments to demonstrate that their request for more funding is based upon an increase in the number of mandated children, or that the treatment costs have increased due to the services needs of the children.

Because base allocations are often not sufficient to serve their mandated populations, many localities must request supplemental funds each year and present additional data to justify this request to the Office of Comprehensive Services (OCS). Thus, a key issue considered by the Steering Committee is whether a larger percent of dollars can be shifted from the supplemental pool into the initial base allocation without exposing the State to any undue fiduciary risk. It is expected that this policy change would greatly reduce the number of supplemental submissions, while providing better data to support more accurate program caseload and cost projections.

Recommendations

Near Term Action:

- Freeze supplemental funding at the FY 03 level and place any new dollars appropriated into the base allocation.

- Separate child specific data from the supplemental process with the understanding that the data collection will be addressed in some manner to increase the quantity of data provided to the state.

Long Term Action:

- Complete a systemic study of the allocation formula and consider creating an efficiency incentive related to the base allocation.

- Consider elimination of the local match for Medicaid cases. This is not feasible in the current fiscal climate.

2003 Update:

- The 2003 Budget (Chapter 1042) held steady the general funds set aside for the state share of supplemental appropriations (Item 299 C.2.a.). New general fund dollars were appropriated into the base allocation.

- Supplemental request data has been folded into the new CSA database, which will be discussed later in this report.

- Long term recommendations will be considered in the next biennium as appropriate.

The State Organization and Structure of CSA

Statement of the Problem

State-level management of CSA is predicated on the concept of inter-agency cooperation and local control. As a result, no one agency is responsible for the program's administration. Instead, CSA policy development, program management, and oversight responsibilities are vested with multiple agencies. Studies have shown that the benefits of this novel approach to management appear to be offset by the lack of attention given to the basic elements of program management. As the program has grown in size and complexity, this management structure does not appear to have yielded the stewardship needed to ensure the proper management of the program.

Recommendations

Near Term Action:

Develop a legislative package on State Structure to include the following changes.

- The State Executive Council (SEC) to be chaired by the SHHR or a designated Deputy SHHR (Presently, the chair is elected by the members of the SEC).
- The State and Local Advisory Team (SLAT) to be chaired by a local government representative (Currently, the chair is elected by the membership and focus is often State operations); to advise SEC on state agency policy and impact on localities.
- As with any state agency, dispute resolution is through SHHR and the Governor (Currently, the dispute resolution involves an informal review by OCS and a formal review by the SEC).

2003 Update:

- Legislation adopted by the 2003 General Assembly accomplished the first two recommendations above.

- The third recommendation was accomplished administratively.

- The SEC is in the process of discussing the transition to a futuristic, interagency policy and planning focus and of providing direction to the SLAT on locally oriented projects.

Strategies for Increasing Collection of Federal Reimbursement

Statement of the Problem

Funding for CSA is a state-local partnership. In FY 01, the local share averaged 37 percent. Since the inception of the program, CSA has been defined as the final funding source, to be used only after other resources (programmatic and fiscal) were explored. Use of other funding sources saves both state and local dollars. While many localities place considerable importance on locating alternative funding sources, others do not.

Recently, particular emphasis has been placed on exploration the use of Title IVE and Medicaid as additional funding sources for CSA. The Department of Social Services has reportedly simplified administrative requirements related to eligibility determination for Title IVE and provided training to local agencies. However, in terms of census and expenditures, Title IV-E foster care growth has not kept pace with growth in non-IV-E foster care.

In 1998, the General Assembly directed that two additional services -- treatment foster care and residential psychiatric services -- become Medicaid reimbursable. Still, since the addition of those services, Medicaid utilization patterns have been significantly below the level that was originally predicted. In view of the potential cost savings at the state and local level, more work is needed toward greater use federal funding sources available to replace state and or local funding.

Recommendations

Near Term Action

- Expand the scope of Medicaid coverage. Consideration will be given to additional levels of residential treatment; expansion of case management; elimination of the limit on Intensive In-Home Services accompanied by required review and reauthorization; reassessment of the current definition of "family" for Intensive In-Home Services. Additionally, FAMIS will be examined as an alternative funding source for some children normally served in CSA.

- Determine what barriers exist to impede local use of Title IV-E and determine if the scope of use can be expanded further.

- Continue and expand training for State and local agencies s related to the use of: EPSDT, Medicaid, and Title IVE.

Long Term Action

- Examine the feasibility of requiring CSA service providers to become Medicaid certified as a condition of participating in the CSA program.

2003 Update

- The Department of Medical Assistance Services is in the process of implementing changes authorized by the 2003 Budget to include additional Treatment Foster Care case management and additional residential coverage with two levels of step-down care.

- The Department of Social Services has worked to enable localities to claim certain administrative and maintenance expenditures that were not previously allowed under Title IV-E.

- Additionally, the 2003 Budget directed the use of Medicaid providers by localities whenever available and appropriate.

- Trainings on Medicaid/FAMIS, Title IV-E and CSA related topics are scheduled or are in the planning stages. These trainings are offered through the collaborative efforts of the OCS and CSA partner agencies.

- Additionally, the Technical Assistance Advisory Group (TAG), comprised of a number of diverse stakeholder representatives, continues to provide input to the OCS on an on-going basis regarding technical assistance and training needs.

Managing, Evaluating and Monitoring Care in CSA

Statement of the Problem

A hallmark of CSA is the significant authority vested with the local governments for the operation and management of the program. Studies conducted during the early years of CSA indicated the many localities were not implementing CSA according to legislative intent. Further, there was no uniformity in the assessment process for children, and only a small number of localities had formal utilization review programs. Since that time, CSA has required localities to use a uniform assessment instrument and participate in a utilization management (UM) process. Nonetheless, questions have surfaced about the degree and extent to which localities are using the State's uniform assessment instrument. In addition, the UM process has not won widespread acceptance among local governments and questions about the effectiveness of the program remain. Due to these factors and the absence of a comprehensive data system, the State has been unable to adequately assess the appropriateness and quality of care that children are receiving through the program.

Recommendations

Near Term Action:

- The OCS will facilitate the provision of additional utilization management training for localities, as well as training to support the proper use of the Child and Adolescent Functional Assessment Scale (CAFAS™) assessment instrument.

- Localities should continue using the (CAFAS™) uniform assessment instrument but with 8 versus 5 scales. This will require revision on the Levels of Need Chart, which contains guidelines for services/treatment. High Priority.

- A designee of the Secretary of Health and Human Resources will conduct an evaluation of the alternatives to the CAFAS™ uniform assessment instrument currently used in CSA, to include the Childhood Severity of Psychiatric Illness (CSPI) assessment instrument.

2003 Update:

- The OCS continues to provide consultation to localities regarding utilization management and review.

- An updated Model Utilization Management Plan has been distributed to localities.

- Instructions for changing to the 8 scale CAFAS™, including a revised Levels of Need Chart, have been provided to localities by the OCS.

- Fall training has been scheduled with the author of the CAFAS™ assessment instrument.

- As alternatives to this instrument were considered, as well as the training and costs of moving to another instrument, CSA partners agreed that a change to another instrument should be postponed. Implementation of the new data-set will bring more knowledge on the use of the CAFAS™ and the risk behavior factors it provides. The resulting analysis will enable better informed decisions in the future as to continued use of this instrument.

Managed Care As An Option For CSA

Statement of The Problem

While a number of the recommendations proffered in this report have the potential to slow the growth of CSA general fund expenditures, these proposed changes are unlikely to produce large-scale reductions in the cost of the program. As a result, a significant amount of interest has been expressed in the concept of managed care as a basis for curbing CSA expenditure growth. In the strictest sense, a statewide CSA managed care program would vest a third party -- typically a private corporation -- with the authority needed to managed the provision of mental health services to children in the program. With this arrangement, it its theorized that the sometimes wide and unexplained variations that occur in CSA expenditures can be reduced through greater control and management of the treatment planning and service delivery process for children.

Understandably, there are a number of concerns and questions about the appropriateness of the managed care model for CSA. For example, local agencies point out that they face clear statutory requirements for providing sum sufficient services to certain children in CSA. Any actions by managed care authorities to restrict treatment under these circumstances would, it is argued, be in obvious conflict with that authority. Efforts to eliminate this conflict would require that the legal responsibility for the care of these children be shifted to the private managed care entity – an untested and potentially risky strategy.

Despite these concerns, many familiar with the operation of CSA acknowledge that questions about the local management of CSA funded services, lingering concerns about the utilization review process, and the persistent cost increases in the program requires that some aspects of managed care be given more consideration as a possible vehicle for reducing expenditures in the program.

Recommendation

Long Term Action:

- A designee of the Secretary of Health and Human Resources will lead a study of options existing in managed care technologies, which are appropriate to Virginia's system of care, to assist with the management of CSA.

2003 Update:

- Although this was a long term action item, representatives of SHHR and OCS moved forward to meet with providers to discuss a care management approach.

- Additionally, a local government strategy group was formed to assist with identifying issues, concerns and difficulties in serving youth in the CSA and for proposing solutions.

- The group has met on three occasions to explore care management technologies, best practices, and other quality of care and expenditure improvements. Future meetings are also planned.

- With the ability to monitor more closely the services and costs of CSA through the recently implemented data-set, it appears we will be better able to understand the nuances of program management.

- Continued review of potential care management technologies that may benefit service delivery to children and their families will remain an ongoing project.

Assessment and Development of Negotiated Statewide Contracts for Services Purchased by State and Local Agencies

Statement of the Problem

Currently, the Code of Virginia (§2.2-5214) requires that the "rates paid for services purchased pursuant to this chapter shall be determined by competition of the market place and by a process sufficiently flexible to ensure that family assessment and planning teams and providers can meet the needs of individual children and families referred to them." Both the Joint Legislative Audit and Review Commission's (JLARC) Review of CSA (1998) and the Department of Planning and Budget's (DPB) Review of the Budget for CSA (2000) noted the relationship of provider rates/local level negotiations and CSA costs. However, the ability of local CSA programs to negotiate the best rates possible for the services they purchase is impeded by bundled service rates. Moreover, both the service providers and local officials agree that the contracting process would be significantly improved if the State adopted standard contract language.

Recommendations

Near Term Action:

- Development of a standardized contract (by a diverse stakeholder group lead by the OCS) to be used statewide with allowance for addendums by individual localities.

- Provision for "unbundling" of services. This is to be done in conjunction with efforts to develop standardized contracting.

Long Term Action:

- On-going enhancement of Service Fee Directory (an electronic directory developed to assist providers in sharing information regarding services and fees) to enable localities to become informed purchasers of service. The directory is currently located on the CSA web site. High Priority.

2003 Update

- A group of stakeholders came together to develop a standardized contract to assist localities and providers in working together to better serve the Commonwealth's children. While use of this instrument is not mandated, it will serve as a basic tool to help localities and providers understand where we are and where we are going as a system or with an individual child.

- The web-based service fee directory has been updated to include licensing information as well as discrete service and rate information.

- Additional work on unbundling of services continues through a Department of Social Services federal maximization stakeholder group.

- DMAS is coordinating unbundling of services with the expansion of residential and case management services previously mentioned.

Coordinated Collection Of Information Among State Agencies

Statement of the Problem:

There has been on going concern about the limited amount of data available on children served through CSA. The Office of Comprehensive Services (OCS) collects limited demographic data on the CSA population. A considerable amount of data exists on the children in CSA in various state and local agencies. However, these data are in both hard copy and electronic files. There is no consistency around the types of data that are automated. Further, the absence of unique identifiers for CSA cases, and the lack of compatibility across the various legacy systems make data sharing an expensive and technologically challenging proposition. Additionally, as will be discussed later, the lack of available data has complicated the task of projecting caseloads, service needs and costs for the program.

Recommendations

Near Term Action:

- Develop interim data reporting to expand quantity of data (but not data elements) that is currently collected by OCS. The expectation will be that data currently collected only on children involved in supplemental funding requests will now be submitted on all CSA children on a point in time basis. It is anticipated that reporting requirements will be combined to reduce state and local administrative burden. This project will be lead by the Office of Comprehensive Services in collaboration with technical experts and local governments.

Long Term Action:

- The Office of the Secretary of Health and Human Resources will take the lead in effort to further explore and resolve issues related to the establishment of an automated information system containing data on all children who receive CSA services. This will be an expansion of the project involving state agency MIS Directors and related to coordinated collection of information among state agencies.

2003 Update

- The task group formed as part of the 2002 SHHR Study and comprised of local government representatives, state agency MIS Directors, OCS representatives and a Deputy Secretary continued to meet in 2003.

- As a result, a new data-set for CSA was implemented on July 1, 2003. Some 35 data elements and additional data fields will be reported to the state on a quarterly basis. The first report is due on or before October 31, 2003.

- Included will be the ability to look at child-specific costs and service information.

- There is an optional reporting capability between an expanded web-based reporting system and an electronic data file submission designed to accommodate specific programs used by some localities.

- An interface of the CSA data-set with the DSS data warehouse will provide the framework for consolidating state agency collection of child specific data.

Projections of Caseloads, Service Needs, and Costs

Statement of the Problem

While projections of caseload and costs have been accurate over the years, there has been a lack of sufficient advanced integrated data to justify an increased initial appropriation. As has been discussed, the range and type of program information collected from localities is quite narrow. This greatly limits the prospect of successful forecasting. The only reliable data available -- from CSA payment records -- cannot support more sophisticated statistical forecasting. The only data available for projecting expenditures is the record of aggregate annual expenditures and overall growth rates.

In light of these problems, one task group was charged with considering the data and trend analysis necessary to project caseloads, service needs and costs in a way that will enable public policy makers to be proactive in addressing the challenges in CSA. However, until such time as the data collection issue is resolved, any recommendations must be put aside for future consideration.

Recommendation

Long Term Action

- All work on forecasting should be held in abeyance until CSA information management needs are appropriately addressed. The chair of the task group that considered projections of caseloads, service needs and costs will be asked to serve as a resource to the group considering technical processes. In turn, DPB will be kept apprised of changes as they occur and be prepared to begin taking advantage of increased forecasting capabilities, particularly as improved data becomes available through the project discussed above, in conjunction with the six year financial plan.

2003 Update

- The long-term recommendation will be revisited. The first report generated by the new data-set is not due from localities until October 31, 2003. A meeting was held in the summer of 2003 with DPB to discuss progress and forecasting capabilities.

A Blueprint For Change In CSA Status As of June 30, 2003			
Action	**Next Step(s)**	**Lead Responsibility**	**Status**
<u>Near Term-High Priority</u>			
Freeze supplemental funding at the FY 03 level and place any new dollars appropriated into the base allocation.	Prepare budget amendment	Office of Comprehensive Services	**Completed with language in the Appropriations Act, Chapter 1042, Item 299**
Develop interim data reporting to expand quantity of data (but not data elements) that is currently collected by OCS. Will expect data currently collected to be submitted on all CSA children on a point in time basis. Will attempt to blend reporting requirements.	Work with technical experts and local representatives to develop the reporting methodology	Office of Comprehensive Services	**Reporting is now done web based. While working closely with the SHHR Information Technology Work Group, a minimum data set for CSA has been developed and approved. The data set was implemented in July 2003, using both a web based application or local government direct interface from existing software.**
Upon the adoption of the above referenced interim data reporting process, separate child specific data from the supplemental process.	Following completion of the above action and provision of training to localities, discontinue current supplemental data reporting process.	Office of Comprehensive Services	**Begins for FY 04, with the implementation of the above item**
Expand the scope of Medicaid coverage, to include examination of FAMIS.	SHHR to direct DMAS to consider expanded options recommended by the task group	Department of Medical Assistance Services	**Completed in Chapter 1042 budget; DMAS staff are working to operationalize these requirements**
Determine what barriers exist to impede local use of Title IV-E and determine if the scope of use can be expanded further.	SHHR to direct DSS to consider barriers and potential areas for expansion	Department of Social Services	**DSS finalizing information document summarizing and defining eligible Title IV-E expenditures. Training to subsequently be scheduled.**

A Blueprint For Change In CSA Status As of June 30, 2003			
Action	**Next Step(s)**	**Lead Responsibility**	**Status**
<u>Near Term-High Priority cont.</u>			
Coordinating state agencies training such as but not limited to: EPSDT, use of CAFAS in service planning, and negotiating with providers.	Utilizing the existing, develop and provide training that will meet local partners' needs.	Office of Comprehensive Services	**TAG continues to coordinate state training opportunities. Preparations for CAFAS refresher training have begun. Model UM plan posted to assist localities with service planning, negotiations. Model Plan utilizes local government's "best practices".**
Development of a standardized provider contract to be used statewide with allowance for addendums by individual localities.	Assemble a group of diverse stakeholders	Office of Comprehensive Services	**Workgroup comprised of private providers, local governments and state agency representatives completed contract development; Posted on CSA web site June 2003**
Provide for "unbundling" of services.	To be done in conjunction or parallel effort with the item related to standardized contracting.	Office of Comprehensive Services	**Workgroup is concentrating initial efforts on maximizing federal funding opportunities. Coordinating service unbundling effort with the DSS federal maximization group. DMAS is coordinating with expansion efforts of residential and case management services.**
Continue use of the CAFAS™ instrument with training noted above.	Notify localities of change to the 8 scale CAFAS.	Office of Comprehensive Services	**Changed to the 8 scale CAFAS accomplished with implementation of the CSA data set**
Evaluation of an alternative to the CAFAS™	Develop an evaluative process	Secretary of Health and Human Services Designee	**Any changes to be implemented during the next biennium. OCS has begun an informal review of alternatives to the CAFAS for future consideration of an advisory group.**

A Blueprint For Change In CSA Status As of June 30, 2003			
Action	**Next Step(s)**	**Lead Responsibility**	**Status**
LONG TERM-HIGH PRIORITY			
Consider creating an efficiency incentive related to the base allocation.	Work with local representatives to complete a systemic study of the allocation formula	Office of Comprehensive Services	**Work has not as of yet begun - Will be highly dependent on budgetary constraints**
Enhancement of Service Fee Directory to enable localities to become informed purchasers of service…link to licensing information.	Work with technical experts and local representatives to develop the necessary system changes	Office of Comprehensive Services	**Directory has been enhanced to provide direct linkage to the DSS Directory of Children's Residential Services (Interdepartmental Licensure), DMAS residential and treatment foster care providers. Will look to other licensing agencies for additional links.**
Expansion of the project related to coordinated collection of information among state agencies to further explore and resolve issues related to the technical processes.	Office of SHHR to form a group of experts to carry this project forward. It is anticipated that the group comprised primarily of state agency MIS Directors will continue with expanded membership.	Secretary of Health and Human Services Designee	**SHHR IT workgroup formed to resolve technical issues regarding data collection. With the interface of the CSA data set with the DSS Data Warehouse, began preliminary work on the framework for consolidating state agency collection of child specific data**
On-going review of forecasting capabilities, particularly as improved data becomes available through the project discussed above, in conjunction with the six year financial plan.	The chair of the task group that considered caseloads, service needs and costs will be asked to serve as a resource to the group considering technical processes. In turn, DPB can be kept apprised of changes as they occur.	Department of Planning and Budget	**Included within the scope of the CSA data set implementation is analyzing child specific cost and service information. OCS is developing internal reports to analyze locality child specific data from the CSA data set for forecasting, policy and planning purposes.**

A Blueprint For Change In CSA Status As of June 30, 2003			
Action	**Next Step(s)**	**Lead Responsibility**	**Status**
LONG TERM-HIGH PRIORITY cont.			
Study of options existing in managed care technologies, which are appropriate to Virginia's system of care, to assist with the management of CSA. To include issues related to evaluation and monitoring.	Office of SHHR to form a group of experts to carry this project forward.	Secretary of Health and Human Services Designee	A care management advisory group met to discuss managed care technologies applicable to CSA. In addition, two meeting have been held with a third one planned with local governments to review cost and quality of care strategies applicable to CSA.

THE COMPREHENSIVE SERVICES ACT FOR AT RISK YOUTH AND FAMILIES
State Executive Council

Development of a Strategic Plan and Strategic Directions
June 2004

PURPOSE OF THE STATE EXECUTIVE COUNCIL (SEC)

The purpose and objectives of the Council shall be to assure collaborative programmatic policy development, fiscal policy development and administrative oversight for the efficient and effective provision of child centered, family focused and community based services to eligible emotionally and behaviorally troubled children/youth and their families in the least restrictive, appropriate environment. Further, the Council assures the Governor, and Cabinet Secretaries are knowledgeable on matters related to the aforementioned areas. (Article II of the State Executive Council Bylaws)

MISSION STATEMENT

To direct a cost-effective collaborative system of services for youths that is child centered, family focused and community based. (Comprehensive Services for At-Risk Youth and Families, Strategic Plan Update 2004-2006 Biennium)

GOAL OF THE SEC STRATEGIC PLAN (DRAFT STATEMENT)

To ensure that the SEC has an active plan that continues to address key issues effecting policy, communication, funding, data management, and administration of the Comprehensive Services Act programs.

PROPOSED STRATEGIC DIRECTIONS

CHALLENGE 1. To develop policies that improves access to care for all at-risk and troubled youth and their families.

Potential Issues/Goals:

a. Non-mandated children and youth

b. Relinquishment of parental custody (The development of models to reduce this perceived mandate as well as the issues highlighted in the Office of the Attorney General Opinion Number 04-012 [March 2004].)

c. Role of parents in CSA process (Heighten the role of parents in the CSA process.)

d. Early intervention services (Annually, assess the impact of early intervention services on the CSA programs.)

CHALLENGE 2. To promote open communication, ownership, and active participation among all CSA participants: parents and their children, local and state decision makers and governments, and private agencies.

Potential Issues/Goals:

Possible methods for communication:

- Newsletter
- Regional Forums - Target local and state decision makers by partnering with VACO, VML, the Association of School Superintendents, Judges and VCOPPA.
- Inclusion of stakeholders on all committees, task forces, etc.
- Continued best practices dissemination

CHALLENGE 3. To maximize and efficiently utilize all available local, state, federal and private funding streams that are aligned with/complementary to Comprehensive Services Act principles.

Potential Issues/Goals:

a. Funding and allocation methodologies, such as local match requirements, unbundling of reimbursement, and payment for education services

b. Medicaid providers of CSA services

c. Integration of CSA with local budgets

CHALLENGE 4. To develop and implement a quality improvement program that uses customer feedback, client outcomes, and program and fiscal data to improve the operation and management of CSA, OCS, and SEC.

Potential Issues/Goals:

To be developed

CHALLENGE 5. To develop program efficiencies, supports including uniformity of tools, which minimizes CSA administrative processing and expenses at all levels: state, local, and private agencies.

Potential Issues/Goals:

To be developed

Report Of The
State Executive Council Workgroup
On
The Relinquishment of Custody for the
Purpose of
Accessing Behavioral Health Treatment

November 1, 2005

Introduction

Last year, based on widespread concerns within the Commonwealth regarding the issue of parents being faced with the choice of giving up custody of their child with severe emotional disturbances solely to obtain behavioral health treatment this issue, the 2004 Session of the Virginia General Assembly directed that:

> "The State Executive Council for the Comprehensive Services Act shall investigate the reasons leading to the practice of parents relinquishing custody of their children solely to obtain necessary and appropriate mental health services. The State Executive Council shall recommend policy options, including legislative action if appropriate, for abolishing this practice while continuing to make the services available and accessible to children, and report to the Chairmen of the House Appropriations and Senate Finance Committees, and to the Chairman of the Joint Commission on Health Care, by November 1, 2004." (Item 299 F)

As chair of the State Executive Council, The Honorable Jane H. Woods, Secretary of Health and Human Resources, established a widely representative task force to complete this study. This task force consisted of 32 members and was chaired by Raymond R. Ratke, Chief Deputy Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services. During 2004, the task force held a total of seven meetings including an extended session to hear from six families who faced this impossible decision and experienced the heart wrenching and destructive consequences. A preliminary report was issued on November 1, 2004 that contained a comprehensive review of the many complicated issues involved in this practice, ten study findings, and 18 recommendations. As a result of the complex issues involved, it was also recommended that the workgroup continue to study this practice for an additional year. This initial report is attached as an appendix.

The primary conclusion contained in this 2004 report was that **"this problem is a direct result of inadequate access to and availability of prevention, early intervention, and intensive mental health and substance abuse treatment services for children and adolescents".**

Progress Implementing Recommendations as Contained in the Preliminary Report:

Significant progress has been made over the past year in addressing the recommendations outlined by the taskforce in 2004, including the following:

- The Virginia Department of Social Services has developed and implemented a method for tracking the incidence of custody

relinquishment for the sole purpose of obtaining behavioral health treatment services.

- Family organizations established a statewide network for child and family advocacy, information, and referral to families to assist them in accessing available services. The Department of Mental Health, Mental Retardation and Substance Abuse Services entering into a contract with an organization called Parents and Children Coping Together in conjunction with Medical Home Plus initiated the development of this network.

- The Office of Comprehensive Services and the CSA State and Local Advisory Team are becoming proactive in:
    - Engaging families;
    - Providing consistent guidance on policy and program implementation; and
    - Providing training, technical assistance and best practices to communities in implementing effective local systems of care.

- Additional funding was appropriated during the FY 2005 session of the Virginia General Assembly for expanding services to the non-mandated youth population and for developing two projects to demonstrate the effectiveness of a "systems of care" model of service delivery for youth and families.

Work of the Taskforce During FY 2005

The full workgroup met six times throughout 2005 and focused on the following areas:

1. Practices that reduce, eliminate, and/or minimize the negative impact of custody relinquishment while providing access to behavioral health treatment:
    - Within Virginia; and
    - In other states.
2. Recommendations for immediate and long term policy and funding changes that will help to abolish this practice in Virginia.

In meetings specifically intended to focus on the above areas, the taskforce met with a panel of representatives from localities that use non-custodial agreements to reduce custody relinquishment. The taskforce also met with a national expert regarding the services and programs provided in other states that have successfully reduced the incidence of custody relinquishment.

As a result of these meetings and the general work of the taskforce, the following recommendations were developed and approved by the State Executive Council for the Comprehensive Services Act.

FY 2005 Taskforce Recommendations

1. Recommend consideration of a "Section 1" bill or Joint Resolution establishing the intent of the Commonwealth to make behavioral health services available to children who need them without requiring parents to relinquish custody. Consider requiring reports to the Commission on Youth and/or the JCHC Behavioral Health Care Subcommittee on progress made in achieving this goal.

2. Establish a taskforce to review and recommend revisions to all sections of the *Code of Virginia* related to the implementation of non-custodial agreements with the intent of making these agreements less adversarial and onerous for families, to include but not limited to the following issues:
    - Criminal background checks
    - Co-payments
    - Child support payments

3. Amend the *Code of Virginia* to eliminate required criminal background checks of parents with children under non-custodial foster care agreements and temporary entrustments when children are returning home from placements (including residential placements, group homes, respite or treatment foster homes).

4. Through *Code* revisions or policy interpretation, ensure that children who receive CSA services through mandated special education eligibility and who have a diagnosis of a serious emotional disturbance receive the necessary behavioral health treatment services, supports, and case management specified in the individualized family services plans as approved by the Community Policy and Management Teams through CSA mandated funds.

5. Explore federal funding options allowable under Medicaid (including the Home and Community–Based Waiver, Katie Beckett Option, and EPSDT), FAMIS, and through Title IV-E waivers to expand access and availability of services for children. Ensure that the same eligibility and benefits, to the extent allowed by federal law, are available for children under both Medicaid and FAMIS.

6. Increase access to community services through expanding the number of demonstration projects implementing system of care models focusing on evidence-based practices and incorporating the use of diversion protocols.

7. Funding Recommendations:
    - Increase funding and fiscal incentives to encourage the development of community services statewide for mandated and non-mandated children.
    - Increase funding for serving non-mandated children through the various state child-serving agencies.

- Provide access to start up funds for localities to develop community services to prevent or return children from out of community placements.
- Incorporate the use of diversion protocols as community-based services are expanded in communities.

Conclusion

The primary conclusion initially reached by this workgroup in 2004 has not changed. The problem of parents being faced with the decision to give up custody of their child in order to obtain behavioral healthcare services is a direct result of inadequate access to and availability of prevention, early intervention, and intensive mental health and substance abuse treatment services for children and adolescents.

While the work of this taskforce concludes with this report, the State Executive Council and participating child serving agencies will continue to address the underlying causes of this practice and to implement improvements in Virginia's child serving system to improve access to care. Likewise, the Commonwealth should continue to support all efforts to make a full array of affordable behavioral health services available to children and adolescents based on their level of service need rather than their "mandated" or "non-mandated" status under the Comprehensive Services Act.

Report Of The
State Executive Council Workgroup
On
The Relinquishment of Custody for the
Purpose of
Accessing Behavioral Health Treatment

November 1, 2004

Table of Contents

A. INTRODUCTION

The issue of parents being faced with the choice of giving up custody of their child with severe emotional disturbances solely to obtain behavioral health treatment is a serious and significant problem in Virginia and the nation. A publication of the Bazelon Center for Mental Health Law calls this problem "the tragic result of failure to meet children's mental health needs." The President's New Freedom Commission on Mental Health recommends the "elimination of conditions under which parents must forfeit parental rights so that their children with serious emotional disturbances can receive adequate mental health treatment." Based on widespread concerns within the Commonwealth regarding this issue, the 2004 Session of the Virginia General Assembly directed that:

> "The State Executive Council for the Comprehensive Services Act shall investigate the reasons leading to the practice of parents relinquishing custody of their children solely to obtain necessary and appropriate mental health services. The State Executive Council shall recommend policy options, including legislative action if appropriate, for abolishing this practice while continuing to make the services available and accessible to children, and report to the Chairmen of the House Appropriations and Senate Finance Committees, and to the Chairman of the Joint Commission on Health Care, by November 1, 2004." (Item 299 F)

As chair of the State Executive Council, The Honorable Jane H. Woods, Secretary of Health and Human Resources, established a widely representative task force to complete this study. This task force consisted of 32 members and was chaired by Raymond R. Ratke, chief deputy commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services. The task force held a total of seven meetings including an extended session to hear from six families who faced this impossible decision and experienced the heart wrenching and destructive consequences.

The task force initially focused on three primary areas of inquiry:

1. The extent to which custody relinquishment for the purpose of obtaining behavioral health treatment occurs and the related impacts on children, families and communities.
2. The causes, factors, policies, procedures and practices relating to custody relinquishment.
3. The existing or available best practices or model programs that offer access to services without requiring custody relinquishment (except where necessary and appropriate).

While given the extreme complexity and breadth of the issues relating to this problem, this group has not fully reached conclusion regarding these three areas.

The efforts of the task force have resulted in ten primary "findings" and 18 comprehensive recommendations.

The essential and most important conclusion of the work of this task force is that this problem is a direct result of inadequate access to and availability of prevention, early intervention, and intensive mental health and substance abuse treatment services for children and adolescents.

B. FINDINGS

1. For a significant number of families, the only way to access resources for behavioral health treatment services for their children is to relinquish custody.

2. Relinquishing custody under these circumstances has myriad negative consequences, sometimes severe and devastating, for families and their children, and communities.

3. Relinquishing custody solely for this purpose uses Virginia's child serving systems in unintended, inappropriate, and inefficient ways.

4. Virginia laws, policies, and practices that govern custody relinquishment are primarily designed for purposes other than addressing children's treatment needs and, as such, can be experienced as adversarial by parents.

5. Limited availability, lack of funding, or inadequate insurance coverage for behavioral health treatment service are primary reasons families relinquish custody in order to obtain these services.

6. Virginia's child serving system, comprised of multiple state and local agencies, is fragmented both programmatically and in its funding streams. This complex fragmentation poses significant challenges for families and the professionals who serve them.

7. Extreme variability exists across localities in the Commonwealth and within localities themselves regarding the consistent application of policies and practices, service availability and resources.

8. Virginia lacks a strong, organized family advocacy network. Such networks have proven in other states to be effective resources in helping families of children with serious emotional disturbances navigate the complex public and private systems of children's services. These networks have also successfully advocated for system improvement.

9. In the short-term, changes in code, regulation, policy, and practice to Virginia's *current* system of care for children will improve access to behavioral health services and reduce some the negative effects of custody relinquishment for *some* families.

10. In the long term, *Transforming* and adequately funding Virginia's system of care for children and families, building on the CSA and based on nationally recognized and evidence-based solutions, will significantly improve access to behavioral health services and eliminate the need for relinquishment of custody.

C. RECOMMENDATIONS

The State Executive Council (SEC) shall be responsible for implementing and monitoring all recommendations contained in this report. To this end, the SEC should analyze and ensure that correct infrastructure and commitment is in place at the state level to ensure, support, and provide continued enhancement of the Comprehensive Services Act for At-Risk Youth and Families (CSA) as measured against Systems of Care guidelines and principles.

Given the complexity of this issue and the need for oversight and monitoring of progress, the workgroup recommends that this study continue for one additional year with a final report from the SEC to the Joint Commission on Health Care by November 1, 2005. The next task of this workgroup is the development of an implementation plan with specific target dates for the completion of these recommendations. Finally, to further enhance the coordination and monitoring of the implementation of these recommendations, these recommendations should be incorporated, where appropriate, into the SEC strategic planning process.

Recommendations for System Reform

1. Develop the mechanism to coordinate with other affected Secretariats all state level children's services in the Commonwealth. This coordination should include, but not be limited to, the current efforts underway related to the state's Program Improvement Plan (PIP) developed in response to the federal Child and Family Services Review (CFSR) to improve access to mental health services for youth, and the expansion and enhancement of access to child and adolescent mental health services.

2. Examine the State Corporation Commission (SCC), Bureau of Insurance's role in exploring mental health parity for at-risk youth and the inclusion of a full service continuum in private sector insurance. Specifically, explore the use of private insurance funds for home-based, day treatment, and crisis stabilization in order to prevent more expensive hospitalization. Further, consider "hold-harmless" in which funding for hospitalization could be redirected without exceeding existing financial risk.

3. The Department of Social Services shall collaborate with other child serving agencies to develop, by July 1, 2005, a method for tracking the incidence of custody relinquishment for the sole purpose of obtaining behavioral health treatment services.

4. Review and analyze alternative models of child serving systems that reduce or eliminate categorical funding, decrease fragmentation, and support cost containment strategies.

5. Support development of an appropriate, accessible, and outcomes based continuum of behavioral health and substance abuse treatment services for Virginia youth that at a minimum includes:

- assessment and diagnosis
- behavioral aide services
- case management services
- crisis residential services
- crisis services
- day treatment/partial hospitalization services
- early intervention and prevention
- family support/education
- home-based services
- inpatient hospital services
- medical management
- mental health consultation
- outpatient psychotherapy
- respite services
- school-based services
- therapeutic foster care, therapeutic group home
- residential treatment centers
- transportation
- wraparound services

Recommendations for Funding Expansion and The Efficient use of Existing Resources

6. Explore differential matches for CSA funding, specifically related to incentives for localities to use CSA non-mandated funds and request necessary policy and code changes that would reduce the local match requirement for localities using their non-mandated CSA allocation.

7. Analyze the financial implications of increasing the CSA targeted non-mandated levels of funding.

8. Review, analyze and develop specific recommendations for development and funding of community based services infrastructure and program start-up.

9. Expand funding for behavioral health services for youth.

10. Explore funding options allowable under the Medicaid and State Children's Health Insurance Programs including those implemented in other states.

Recommendations for Changes in Policy/Code

11. Direct each child serving agency to initiate an immediate review of all policies, procedures and practices and to bring forward specific recommendations for changes that would enhance parental collaboration

and involvement, enhance and expand access to appropriate mental health treatment, and reduce the variability in the implementation of services.

12. The Department of Social Services shall, in collaboration with other state and local partners, revise, disseminate and train localities on clearly defined policies and procedures regarding the use of voluntary placement agreements that will encourage the appropriate use of these options. Areas to be addressed include but are not limited to: collection of child support; access to treatment foster care; and non-custodial foster care case management practices.

13. The Department of Social Services shall put forth revisions to the Code of Virginia, Departmental policy, and if necessary, will promulgate emergency regulations to ensure consistency between public and private child welfare agencies in all areas that effect parental access to the full range of placement services as allowed by the Code of Virginia.

14. Encourage prevention, early intervention and the use of least restrictive, community-based services with differential CSA match rates for localities for these services. Specifically, the SEC shall review and analyze a differential match rate on mandated foster care prevention funding used to purchase community-based, non-residential services.

15. Advocate for changes in federal laws, regulations, and funding to reduce or eliminate the need for families to relinquish custody for the sole purpose of accessing behavioral health treatment services. Specifically, the SEC should advocate for passage of the Family Opportunity Act (S. 622, H.R. 1811) and the Keeping Families Together Act (S. 1704 and H.R. 3243).

Recommendations for Service Improvements and Program Development

16. Continue process to review and identify Virginia and national best practices that demonstrate results in improving access to behavioral health treatment and the reduction of custody relinquishment.

17. Direct all agencies represented on the State Executive Council to develop and implement technical assistance and training for localities focusing on the dissemination of best practices in the areas of access to mental health, parent collaboration, early intervention and development of a system of care model. This can best be achieved by working with the well-established, nationally recognized associations and organizations readily available to state and local jurisdictions.

These resources include:

- National Resource Centers supported by the Children's Bureau of the federal Health and Human Services (available at no cost to Virginia)
- Bazelon Center for Mental Health Law
- Child Welfare League of America
- National Technical Assistance Center for Children's Mental Health, Center for Child Health and Mental Health Policy, Georgetown University Child Development Center
- SAMSHA Center for Mental Health Services – Systems of Care information
- Federation of Families for Children's Mental Health

18. Direct the Department of Mental Health, Mental Retardation and Substance Abuse Services to lead a collaborative effort with other child serving departments, parents, and advocacy organizations to develop and implement a statewide parent/family resource and advocacy program that is coordinated with existing programs and affiliated with the Federation of Families for Children's Mental Health.