

**Residential Services for Children in the
Comprehensive Services Act**

**Utilization, Length of Stay and Expenditures
Statewide and by Locality**

Program Year 2010

Report by:

**Virginia Office of Comprehensive Services for At-Risk Youth & Families
December 15, 2010**

Residential Care in CSA
For Program Year Ending June 30, 2010
December 15, 2010

Mandate and Scope of Report

The 2010 Appropriations Act (*Item 274, B 2.d*) requires the Office of Comprehensive Services for At Risk Youth and Families (*OCS*) to report to the Governor and Chairs of the House Appropriations and Senate Finance Committees on utilization rates and average lengths of stays in residential care statewide and by locality. Each locality is required to submit to OCS “information on utilization of residential facilities for treatment of children and length of stay in such facilities.”

Historically, this report defined residential care as group homes, residential treatment facilities, and psychiatric hospitals. Beginning in 2009, the Commonwealth enacted the Annie E. Casey Strategic consulting Group policy advice to strengthen CSA financial incentives to reduce reliance on residential care (see section *FY09 Major Initiative to Manage the Use of Residential Care*; page 3). In short, the policy modification reduced the local match on community care and increased the local match on the use of congregate (residential) care. Refer to the “*Status on the Implementation of the Comprehensive Services Act Match Rate Incentive for Residential Care*”, November 2010, for additional information regarding current results from this major policy initiative.

To more closely monitor expenditure trends, the State Executive Council, at the June 12, 2008 meeting, developed final CSA match rate and service categories along with service definition. Beginning in 2009, the service categories comprising residential care include group homes, residential treatment facilities along with temporary care facilities, and congregate care education cost for both non-Medicaid and Medicaid funded cases. Previously, the temporary care facility and residential education categories were included in the group home, residential or psychiatric hospital for cost and census information. Beginning in PY09, psychiatric hospital cases were no longer included as part of the residential category.

The attached schedule (Schedule 1) provides utilization (# of Children in Residential Care), length of stay (Average # Residential Days/Child), and expenditure data on residential placements statewide and by locality for program years 2005 through 2010. Program Year (*PY*) is defined as all children’s services that were provided using CSA funds from July 1 through June 30 of each year as reported by local governments through the CSA Data Set.

CSA Statutory Framework

The purpose of the Comprehensive Services Act (*CSA*) is to create a collaborative system of services and funding for troubled youth and their families that is child-centered, family-

focused and community-based. A fundamental purpose of CSA is to preserve and strengthen families through providing appropriate services for children and their families in the least restrictive setting (§ 2.2-5200).

Children who are eligible for CSA services and funds have emotional and/or behavior problems that are significantly disabling in several community settings (*e.g., home, school or with peers*). They require services that are beyond the normal services or routine collaboration across agencies. They require coordinated interventions by at least two agencies (§2.2-5212). State and local governments are mandated by federal and state law to provide services to children who receive foster care services and specific special education services (§2.2-5211.C).

The CSA statute places the primary responsibility, authority and accountability for this federally and state mandated program to community teams. In each community, teams of professionals and family members collaboratively work to improve outcomes for children and families and to control the rate of growth in CSA expenditures. They decide how to provide services across sectors, enabling children to remain in their homes, schools and communities whenever appropriate while protecting the welfare of children and the safety of the public. They pool resources across sectors, including family, private insurance, Medicaid, federal Title IV-E, CSA state pool of funds, private and community resources.

Family Assessment and Planning Teams (*FAPTs*) assess the strengths and needs of children and their families, develop individual family services plans (*IFSPs*), refer children and families to services, and designate case managers to monitor children's progress. The teams are responsible for engaging families in participating in all aspects of assessment, planning and implementation of services (§2.2-5208). The teams are comprised of a parent and representatives from the local child serving agencies (*community services boards, courts service units, social services, and public schools*). They may include a local health department and private provider (§2.2-5207). Communities include other representatives they deem appropriate for their community or for individual children and families served.

The FAPTs work in accordance with policies established by the CSA Community Policy and Management Teams (*CPMTs*). CPMTs have the statutory authority and accountability for managing collaborative efforts and implementing interagency policies that govern CSA in the community. They coordinate community wide planning, develop needed services, maximize and pool resources across sectors, and manage local CSA funds (§2.2-5206). The CPMTs are comprised of a parent, local government official, agency heads from the local child serving agencies (*community services boards, courts service units, health, social services, and public schools*) and a private provider representative (§2.2-5205). Communities include other representatives they deem appropriate.

CSA Coordinators are hired by many, but not all communities to manage local CSA implementation. Each community has a fiscal agent to manage CSA funds.

While local teams make service and funding decisions, the Commonwealth provides the majority of CSA funds to support local decisions.

At the state level, 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 (SLAT), two parents representatives, a public provider and two private providers. 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. SLAT advises the SEC and OCS by managing cooperative efforts at the state level and providing support to community efforts.

FY09 Major Initiative to manage the use of residential care

The Joint Legislative Audit and Review Committee (JLARC) identified that community based service gaps are the primary obstacle to serve children in the most appropriate, least restrictive setting. In 2007/08, the Casey Strategic Consulting Group provided policy advice to strengthen CSA financial incentives to reduce reliance on residential care, serve children in their homes and invest funds for the development of community based services. Though modified during the 2008 General Assembly session, in short, the policy advice consisted of phasing in a system of financial incentives over the biennium that is consistent with the statutory purposes of the CSA:

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

The following are excerpts from the CSA 2008 Appropriations Act, Chapter 879, mandating the establishment of an incentive match rate system for CSA pool fund expenditures:

“Notwithstanding the provisions of C 2 of this Item, beginning July 1, 2008, the Secretary of Health and Human Resources shall oversee the implementation of a system of financial incentives that is consistent with the statutory purposes of the Comprehensive Services Act. The financial incentive system shall use the methodology in place on July 1, 2007, for calculating the base rate for each locality. The Secretary shall establish a work group to implement the changes in state and local match rates for the Comprehensive Services Act (CSA) program. The work group shall include representatives from the Virginia Association of Counties, the Virginia Municipal League, the Virginia League of Social Services Executives, the Virginia Association of Community Service Boards, the Virginia Coalition of Private Providers, the Virginia Association of School Superintendents, the Department of Education, the Department of

Juvenile Justice, and the Office of the Executive Secretary of the Supreme Court. The work group shall examine the impact of the match rate changes on local and state administration of the program, reporting requirements, service development and delivery, quality assurance, utilization management, and care coordination to ensure that children continue to receive appropriate and cost-effective services.

Community Based Services. Beginning July 1, 2008, the local match rate for community based services for each locality shall be reduced by 50 percent.

Localities shall review their caseloads for those individuals who can be served appropriately by community-based services and transition those cases to the community for services. Beginning January 1, 2009, the local match rate for residential services for each locality shall be increased by 15 percent above the fiscal year 2007 base rate after a locality has incurred a total of \$100,000 in residential care expenditures for the period of January 1, 2009, through June 30, 2009. Beginning July 1, 2009, the local match rate for residential services for each locality shall be 25 percent above the fiscal year 2007 base rate after a locality has incurred a total of \$200,000 in residential care expenditures”

Summary Statewide Information on Residential Care

Children served in residential care. There were 3,156 children placed in residential care at some point during PY10. Thus, 18.0% of all CSA children (17,568), or less than one out of every five CSA children, received residential services. This percentage declined almost 3% from PY09 when 21.0% of all children served in CSA (17,628 total children served) were placed in residential (3,697 unduplicated residential placements) at some point during the program year.

There were 541 fewer children placed in residential care in PY10 than in PY09, representing a 14.6% decline. This ratio is consistent to PY09 results, where 616 fewer children were placed in resident care than in PY08, representing less than a 14.3% decrease.

While the children in residential care varied in PY10, near teenage males were the typical recipients. Demographics describing these youth included:

- On average, they were 12 years and 9 month old.
- 61% were male; 39% were female.
- 56% were Caucasian; 37% African American; 1% Asian; 6% undetermined.

Almost two-thirds of the children were originally referred to CSA by local departments of social services (58%). One-quarter of the children were referred by the schools (25%) and the juvenile justice system referred 8%. Fewer referrals came from community service boards (7%) and families (*less than 1%*). Two percent were referred by the Fairfax Interagency Team or another source.

Children are placed in different types of residential care:

- Residential Treatment Facilities: These programs included secure residential treatment facilities and campus style residential programs. An unduplicated count of 1,331 children was placed in these facilities in PY10 representing a 29.8% (565 placements) decline from PY09, when 1,896 children were served in a residential placement.
- Group Homes: An unduplicated count of 1,248 children was served in group homes in PY10 representing a 18.4% decrease from PY09. The unduplicated count in PY09 was 1,529 children.
- Psychiatric Hospitals: An unduplicated count of 47 children was placed in PY10 representing a 19.0% decline from PY09. There was an unduplicated count of 58 children placed in PY09.
- Temporary Care Facilities: An unduplicated count of 93 children was served in a temporary care facility, representing a 32.1% decline from PY09 when local government reported serving 137 children in this category.
- Congregate Educational Services: This service type is a combination of children receiving congregate care educational services as directed by their Individual Education Plan (IEP), children receiving education services while in a residential care or group home facility but placed for purposes other than an IEP, or the education services for a Medicaid child whose other residential services are paid by the Department of Medicaid Assistance services.

In FY10, 1,288 children received Medicaid (service) funded educational services compared to 1,300 in FY09 and another 670 children received non-Medicaid (services) funded congregate care educational services in FY10 compared to 873 in FY09.

Prior to FY09, education services for residential or group home children would have been reported as a component of the total cost (and census) of the residential or group home placement. In the case of a DMAS funded residential placement, the education cost could have either been part of residential cost or could have been reported as private day residential. As with Temporary Care facilities, PY09 was the initial year congregate care education costs were reported separately.

It is important to note that the same child could have been placed in a residential treatment facility, a group home, psychiatric hospital, or temporary facility during the year and were counted in each category. Most all children received some form of CSA funded education services, so that case count is duplicative with the other congregate care categories. However, the numbers of children within each type of residential care were unduplicated if they were placed more than once during the same year.

Length of Stay Varies by Placement

The length of stay in the different types of residential care varied. This calculation was derived by the total number of days children received these services during the year divided by the total number of children served.

- During PY10, children in residential treatment facilities were in care on average 267 days, an average of 8.78 months. This represents a decrease from the PY 09 length of stay where children in residential treatment facilities stayed on average 9.27 months (282 *days*).
- In PY10 there was an overall reduction in the use of residential care. Total use of all residential care declined from 3,697 unduplicated cases in F09 to 3,156 cases in PY10, representing 534 cases or an annual decrease of 14.6%.
- In 2009 a new child assessment instrument, the Child and Adolescent Needs and Strengths Assessment (CANS) was implemented. Once fully integrated statewide, further analysis of children in residential facilities, including their needs and characteristics will be available.
- Below is further information on the CSA census in PY10

The PY10 unduplicated census reported by local governments is 17,568; the PY09 unduplicated census was 17,628. The chart below provides a three year comparison between PY08 through PY10 census by primary expenditure mandate category, isolating the categories that comprise the 60 child count FY2010 census decline:

CSA Unduplicated Census Comparison

Mandate Category	PY2008	PY2009	PY2010	PY 09 -10 Change
Foster Care Services	9,512	8,506	7,802	-704
Foster Care Prevention Services	3,186	3,221	3,801	580
Foster Care Parental Agreements/ non-Custodial Agreements	364	541	556	15
SPED Services	2,663	2,730	2,626	-104
Services in the Public School	1,353	1,355	1,408	53
Non Mandated	1,117	1,275	1,375	100
Total	18,195	17,628	17,568	-60

Again in PY10, the census decline was mainly realized from a decline in foster care services. These categories include (1) Abuse and Neglect – local DSS custody; (2) Child in Need of Services – Custody; (3) Court Ordered for Truancy; and (4) Court Ordered for Delinquent Behaviors. The CSA decline in foster care services coincides with the Department of Social Services OASIS census reports. Their reports indicate an overall foster care census decline from 6,848 children in service in July 2009 to 6,314 in July 2010. (source: The DSS Foster Care Child Demographic Report).

The increase in foster care prevention services indicates an emphasis on early intervention services to minimize the risk of a more restrictive and costly foster care placement (local custody etc)

Expenditures. State and local governments spent \$94.9 million (gross) in CSA expenditures on residential care during PY10, representing 26.6% of all CSA state pool data set gross expenditures (\$356.8 million).

The percentage of total residential cost to total annual gross pool fund cost continues to decline for five consecutive years:

	Residential Cost	Total Gross Cost	%
2010	\$ 94.9M	\$356.8M	26.6%
2009	\$120.8M	\$376.4M	32.1%
2008	\$155.2M	\$388.7M	39.9%
2007	\$149.7M	\$352.8M	42.4%
2006	\$138.1M	\$307.2M	44.9%
2005	\$132.9M	\$283.6M	46.9%

Below are the categories comprising the \$94.9M in PY10 residential expenditures and their respective gross cost:

* Residential Treatment Facilities	\$27.1M
* Group Homes	\$27.9M
* Temporary Care Facilities	\$ 0.9M
* Residential Educational Cost (non-Medicaid and Medicaid)	<u>\$ 39.0M</u>
Total Residential	<u>\$ 94.9M</u>

In addition to CSA funds, communities used Medicaid funds to pay residential services for CSA children to maximize other funding sources. Medicaid expenditures totaled \$82.4M million from July 1, 2009 through June 30, 2010. This total represents a decline of \$13.3M, or 13.9% from the FY09 total of \$95.7M.

Report Methodology

This report used information from the CSA Data Set system as of November 15, 2010. The CSA Data Set contains demographic, service, and expenditure information on all children funded through the CSA state pool of funds. This information is reported three times annually by 131 localities. Information from the 4th quarter data set report, which is cumulative for the program year, was used in determining the results in this report.

Program year (*PYxx*) is defined as all children's services that were provided using CSA funds from July 1 through June 30 of each year.

Length of stay information is derived from:

- Average number of days during the year. This calculation was derived by isolating all children who resided in a residential care setting at some point in PY10 obtained from the 4th quarter CSA Data Set master file. For these children, length of stay was calculated by the total numbers of days in residential care during the year divided by the total number of children in residential care. This calculation allows comparisons of length of stay across years. Schedules 1 used this calculation.

When reviewing these reports, it is also important to note that when the data set was initiated in July 2003, local governments were required to populate information based on placement as of July 1, 2003. Local governments were not required to provide historical placements prior to July 1, 2003. As such, placement information for individual children may not include the pre-July 2003 residential service.

Finally, there are two cautions to consider when reviewing the locality data in the attached schedules. First, localities should carefully review and determine the accuracy of the data they report to OCS. This data is increasingly being used by state and local decision makers. Second, a community may have a significantly higher percentage of children or expenditures than other communities. The reason for this could be that the CSA caseload for the community is small. Thus, one or two children in residential care comprise a larger percentage of the total caseload than communities with more children.

