1. PREVENTION: INCREASE THE AVAILABILITY AND CAPACITY OF EFFECTIVE FOSTER CARE PREVENTION PROGRAMS AND ACCESS TO EARLY INTERVENTION SERVICES.		
ISSUE/BACKGROUND	**SOLUTIONS**	**ACTION (LEGISLATIVE ACTIVITY, BUDGET AMENDMENT, ADMINISTRATIVE ACTION, FUNDING, ADVOCACY)**
CSA costs are driven primarily by the number of children to be served. The majority of those children are in foster care, and the second largest group is special education students. Preventing children from entering foster care and reducing the need for out-of-school special education services is the single best way to control CSA costs. Existing foster care prevention and early childhood development programs have documented success but lack the capacity to serve all children at high risk of placement. [i] Early recognition and effective treatment for younger children -- including increased access to mental health services -- is likely to reduce the need for more intensive and costly services when youth reach their teens. In recent years, older children, ages 12 and up, have become a larger percentage of the foster care caseload.[ii] This trend is evident statewide, as well, where teenage males from high-density localities are the typical recipient of CSA funded services.[iii] Teens are typically more difficult and costly to place and serve. Quality pre-school programs have been proven to reduce significant behavioral concerns in later life and reduce government costs for adolescent and young adult problems. In addition, local school divisions rely on high quality pre-school programs for at-risk youth to prepare children for reading and school readiness in kindergarten, particularly as they seek to meet the Virginia Standards of Learning. In 2003-04, 26% of Charlottesville kindergarten students and 16 % of Albemarle County students were identified as needing intervention services to reach expected reading levels. Current state funding levels do not support the full cost of operation for local pre-school programs such as Albemarle County's Bright Stars preschool program. In FY 2004 Albemarle County received State funding for 32% of the total cost of serving 80 students; in FY 2005, 31% of the total cost of serving 96 students; and in FY 2006, 29% of the total cost of serving 96 students.	1.1 Expand existing early identification and intervention programs and establish programs for children ages five and older, based on Albemarle County's Family Support Worker program in elementary and middle schools.	Funding/advocacy
	1.2 Expand and pay a greater share of the full cost of pre-school for at-risk three and four -year olds.	Funding/advocacy. Develop an equitable early childhood education funding allocation.
	1.3 Pilot the use of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) to identify and support medically necessary services as part of the Charlottesville/Albemarle Family Assessment Planning Team weekly meetings. This would require support for the pilot from the Department of Medical Assistance Services.	Administrative Action: Request assistance from the Secretary of Health and Human Resources, the Department of Medical Assistance Services and the Office of Comprehensive Services (OCS) to develop a pilot model in Charlottesville/Albemarle to increase access to EPSDT services on the part of children served by CSA.
	1.4 Increase funding for mental health services for children who are not Medicaid eligible; especially in the school environment.	Funding/advocacy.

The State currently underutilizes a mandated tool and federal funding source available in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) -- a vital component of the Medicaid system. The EPSDT identifies and provides funding for services discovered by the screen, whether or not such services are covered under a State's Medicaid State Plan, including a comprehensive health and developmental history, vision and dental services, and "such other necessary health care, diagnostic services, treatment and other measures to correct or ameliorate defects and physical and mental illnesses and conditions." [iv] According to VDSS, "The EPSDT is designed to help children and their parents use health resources effectively and efficiently, to assure that all Medicaid-eligible children have access to required health care resources; and to detect and treat health problems early, before they become more complex and their treatment more costly." Further, "it is mandatory… helps children optimally grow and thrive… and.. it need not cost the Commonwealth any additional funding. Many of the non-residential services needed by children are being provided now under the CSA program. These services are being provided at State and local expense, largely without the benefit of Federal ESPDT or Medicaid Funding." [v] The Federal Government will pay 50 percent of the costs of state or local agencies responsible for Medicaid contracting.[vi]		

2. INTERVENTION: INCREASE THE STATE ROLE IN SERVING CHILDREN WITH SEVERE BEHAVIORAL NEEDS BY SUPPORTING A STATE-FUNDED INITIATIVE TO PROVIDE ASSESSMENT AND REFERRAL CAPACITY AT THE LOCAL LEVEL.		
ISSUE/BACKGROUND	**SOLUTIONS**	**ACTION (LEGISLATIVE ACTIVITY, BUDGET AMENDMENT, ADMINISTRATIVE ACTION, FUNDING ADVOCACY)**
Changes in state and federal policies and resources have resulted in the shifting of costs and service responsibility to CSA for children who formerly would have been served in public mental health or correctional facilities.[vii] Public residential mental health treatment facilities for children have been virtually eliminated in the Commonwealth. Children with serious mental and emotional impairments who in the past would have been placed in state facilities now must be served by private programs with CSA funds, shifting costs for these services from state to local government.[viii] In addition, when these children with severe behavioral problems must be placed out-of-home on an emergency basis, there is often no local resource for assessment of their needs and immediate referral to an appropriate placement. In these situations there may not be an opportunity to conduct a thorough assessment of children's problems and service needs prior to placement.[ix] The need to find an immediate and available secure placement can contribute to unnecessarily high costs as some children are placed in more intensive treatment than necessary. Some children, especially those with the most challenging problems, are rejected by or ejected from multiple treatment facilities. For example, a group of high needs children studied in Charlottesville/Albemarle were found to have been ejected from an average of 2.9 facilities that were unable to meet their needs. [x] Some of this can be attributed as well to the inability to conduct a thorough initial assessment of the child's needs due to the mandatory and emergency need for placement. The development of a State-supported secure emergency placement, stabilization and assessment facility will facilitate better cost control and appropriate referrals for services. This facility would provide high quality secure assessment and crisis stabilization services, yet be flexible enough to allow the child to stay beyond the normal window of time for an assessment.	2.1 Create a one-stop secure assessment and crisis stabilization center locally. Provide funding from the Commonwealth of Virginia for a pilot center in Charlottesville/Albemarle for the assessment, diagnosis and referral process. Consider using Community Service Boards (CSB's) to conduct comprehensive assessment and crisis stabilization services.	Administrative Action
	2.2 Explore a waiver for existing state and federal laws which prohibit use of juvenile detention center space for a secure assessment center.	Administrative Action

3. UTILIZATION MANAGEMENT: INCREASE THE STATE ROLE IN UTILIZATION MANAGEMENT BY SUPPORTING THE OFFICE OF COMPREHENSIVE SERVICES TO MANAGE CSA VENDORS FOR EFFECTIVE SERVICES AND COST CONTROL.		
ISSUE/BACKGROUND	**SOLUTIONS**	**ACTION (LEGISLATIVE ACTIVITY, BUDGET AMENDMENT, ADMINISTRATIVE ACTION, FUNDING, ADVOCACY)**
State level contracting with vendors would make the contract management process uniform across the Commonwealth, unburden localities, and improve vendor accountability and cost control. When CSA was established, it was assumed that privatizing the provision of care would help decrease costs; thus fees charged by CSA service providers were not regulated. Yet, vendor rates have increased significantly over time, substantially more than the "cost of living". In CCF's recent CSA Cost Containment study, it was found that vendors' rates increased, on average, 30% between 2002 and 2003 specialized foster care services. Many vendors operate in a "sellers market." There is limited information available about outcomes achieved by service providers and the effectiveness of different treatment modalities they use. Case managers rely mostly on anecdotal experience and word-of mouth in selecting service providers. The Department of Medical Assistance (DMAS) has a prescribed process for how services are to be broken down and reported. Some CSA vendors are not able to be Medicaid providers because their services are not Medicaid reimbursable. The expansion of Medicaid covered services would increase state and local savings. Additionally, federal IV-E payments can be made on behalf of a child for room, board and daily supervision costs but often "daily supervision" is not broken out separately as are room and board services. If vendors would "unbundle" daily supervision -- thus separating it out like room and board -- then localities could get federal reimbursement for those services through Title IV-E. This would save CSA dollars for the State and localities.	3.1 Support OCS to establish state contracts with all CSA Service providers, including assessing the use of outcome based vendor evaluation, negotiating with vendors, and establishing rate regulations. OCS should set conditions that optimize federal funding for services. This would include setting contractual terms and conditions for vendors requiring "unbundling" in order to utilize and maximize other funding sources.	Legislative action and funding support for OCS to assume this responsibility.

4. POLICY: INCREASE RESOURCES FOR LOCALITIES OPERATING CSA TO REFLECT ACTUAL STAFFING, OPERATION AND MANAGEMENT COSTS.		
ISSUE/BACKGROUND	**SOLUTIONS**	**ACTION (LEGISLATIVE ACTIVITY, BUDGET AMENDMENT, ADMINISTRATIVE ACTION, FUNDING, ADVOCACY)**
The costs of operating the CSA program in compliance with State mandates far exceed the administrative funds provided to local communities and represent an "unfunded mandate" to localities. Since the program began in Fiscal Year 1994, CSA caseloads and costs have increased steadily. Expenditures of CSA funds for the City have increased an average of 27% per year and for Albemarle, 22% per year. From 1994 - 2004, administrative staffing for CSA coordination remained unchanged at 1.2 positions in the CCF office. State funding provided for administration of this $12 million program (in fiscal year 2004) was only $30,456 per year. Subsequent to a legislative miscalculation in FY 2005 which reduced the funding level by 21% to $24,070, the FY 2006 funding will return to the previous year's level of funding. Although there has been no increase in State support for program operations for CSA, the localities of Charlottesville and Albemarle have supported increased staff capacity to manage operations by funding one part-time position and other program maintenance activities. In a recent survey of the seven public agencies that participate in CSA in the Charlottesville/Albemarle Comprehensive Service Act system, agency staffed logged 7,777 hours annually, totaling a cost of $270,105.82 annually. These operational costs include attending required meetings for collaborative staffing and administration of CSA. They do not include costs associated with case manager preparation for staffing or agency fiscal processes to document, maintain and account for program expenditures.	4.1 Increase administrative dollars for operating CSA to free up local funds to be used for prevention planning and direct services.	Funding

[i] *CCF CSA Cost Containment Report* Recommendations/Strategy, December 2004, Charlottesville, Virginia.
[ii] Office of Comprehensive Services Briefing for State Executive Council, CSA Retreat, April 2005.
[iii] Ibid. OCS 4-05.
[iv] "EPSDT in Virginia", November 8, 2002, Virginia Department of Social Services paper.

[v] Ibid. VDSS paper.
[vi] Decision Memorandum to the Honorable Jane H. Woods, Secretary of Health and Human Resources, through The Honorable Maurice Jones, Commissioner of Social Services, November 25, 2002 draft.
[vii] Ibid. CCF CSA Cost Containment Study.
[viii] Ibid. CCF study.
[ix] Ibid. CCF study.
[x] Ibid. CCF study.