FREDERICK COUNTY CPMT AGENDA

November 28, 2022
1:00 PM
107 N Kent St
Winchester, VA
1st Floor Conference Room

Agenda

I.	Introductions	
II.	Adoption of Agenda	
III.	Consent Agenda	
	A. October Minutes	
	B. Budget Request Forms	
IV.	Executive Session	
	A. Case Update	
V.	Committee Member Announcements	
VI.	CSA Office Business	Jackie Jury
	A. September Financial Report	
	B. Audit Status Update	
VII.	Old Business	Jackie Jury
	A. Strategic Plan Goal- Satisfaction Survey Meeting Update	
	B. CPMT Leadership Competencies	
	C. Copayment Review	
VIII.	New Business	Jackie Jury
	A. Medicaid/IACCT Policy Revision	
	B. CANS Policy Revision	
IX.	Informational Items	
	A. Flyer for Enhanced Technical Assistance	
	B. MCO Case manager Flyer	
	C. VA Needs Assessment on Adolescent Substance Use	
X.	Assigned Tasks	
XI.	Next CPMT Meeting	
	· November 28, 1:00-3:00pm, 1st Floor Conference Room	
XII.	Adjourn	

**Instructions for Closed Session:

- Motion to convene in Executive Session pursuant to 2.2-3711(A)(4) and (15), and in accordance with the provisions of 2.2-5210 of the Code of Virginia for proceedings to consider the appropriate provision of services and funding for a particular child or family or both who have been referred to the Family Assessment and Planning Team and the Child & Family Team Meeting process, and whose case is being assessed by this team or reviewed by the Community Management and Policy Team
- Motion to return to open session-
- Motion that the Frederick County CPMT certify that to the best of each member's knowledge, (1) only public business matters lawfully exempted from open meeting requirements, and (2) only such public business matters were identified in the motion by which the closed meeting was convened were heard, discussed, or considered in the closed meeting.
- Roll Call Affirmation
- Motion to Approve cases discussed in Executive Session

CPMT Meeting Minutes: Monday, October 24, 2022

The Community Policy and Management Team (CPMT) met in the 1st Floor Conference Room at 107 N Kent St, Winchester, VA 22601 on October 24, 2022.

The following members were present:

- David Alley, Private Provider Representative, Grafton Integrated Health Network
- Jerry Stollings, 26th District Juvenile Court Service Unit
- Jay Tibbs, Frederick County Administration
- Dr. Michele Sandy, Frederick County Public Schools
- Leea Shirley, Lord Fairfax Health District
- Robin Hockman, Northwestern Community Services Board – as Proxy for Denise Acker

The following members were not present:

- Tamara Green, Frederick County Department of Social Services
- Denise Acker, Northwestern Community Services Board

The following non-members were present:

- Jacquelynn Jury, CSA Coordinator
- Robbin Lloyd, CSA

Call to Order: Dr. Michele Sandy, Vice Chair, acting as the CPMT Chair in Denise Acker's absence called the meeting to order at 1:00 pm.

Introductions: Members of the team introduced themselves.

Adoption of Agenda: Jay Tibbs made a motion to adopt the October agenda; David Alley seconded; CPMT approved.

Consent Agenda: The following items were included in the Consent Agenda for CPMT's approval:

- September 26, 2022- CPMT Minutes
- Budget Request Forms – Confidential Under HIPAA. Private Provider abstained from voting on funding for youth receiving services provided by his respective agency or where there may appear to be a personal financial gain from the provision of services.

David Alley made a motion to approve the September Minutes, Jerry Stollings seconded, CPMT approved.

Jay Tibbs made the motion to approve the Budget Request Forms, David Alley seconded, CPMT approved.

Adoption to Convene to Executive Session: On a motion duly made by Leea Shirley and seconded by Jay Tibbs, the CPMT voted unanimously to go into Closed Executive Session to discuss cases confidential by law as permitted by Section §2.2-3711 (A) (4) and (15) and in accordance with the provisions of 2.2-5210 of the Code of Virginia.

Executive Session:

- Case Update
- Chris Rousseau from Haven Mental Health attended to provide more detailed information regarding service provision.

Adoption of Motion to Come Out of Executive Session: Leea Shirley made a motion to come out of Closed Session and reconvene in Open Session, Jay Tibbs seconded; CPMT approved.

Motion and Roll Call Certification of Executive Session: Jay Tibbs made a motion, seconded by David Alley, to Certify to the best of each Frederick County CPMT member's knowledge (1) the only public business matters lawfully exempted from open meeting requirements and (2) only such public business matters were identified in the motion by which the closed meeting was convened were heard, discussed, or considered in the closed meeting.

Michele Sandy	Aye
David Alley	Aye
Jerry Stollings	Aye
Leea Shirley	Aye
Jay Tibbs	Aye
Robin Hockman	Aye- Proxy for Denise Acker
Denise Acker	Not Present
Tamara Green	Not Present

Adoption of Motion to Approve Items Discussed in Executive Session: No actions were needed.

Committee Member Announcements:

- None

CSA Office Business:

- CSA Financial Report:
  - Due to technical difficulties, the Financial Report for September could not be completed and will be presented at the November meeting.

Old Business:

- Audit Status Update – Preliminary findings were provided to the CSA Coordinator and CPMT Chair and included in the CPMT packet. In response to the request for supplemental documentation and observations identified, additional information was submitted.
  - CPMT Governance- The auditor requested a copy of the Local COOP (Continuity of Operations Plan) The newly created Infectious Disease and Preparedness Response plan IDPR was submitted.
  - Both CPMT and FAPT are missing a Parent Representative, and FAPT is missing a Private Provider Representative. An email was sent out to all the CSA Vendors to notify them of the vacancies. Thus far, several vendors have expressed interest.
  - Statement of Economic Interest- A request for a copy of the Statement of Economic Interest was requested for Erica Penn from Embrace Therapeutic Foster Care, a former Private Provider Representative on FAPT. After review, it was learned that one was not obtained, and there was not process in place to notify the Deputy Clerk about members on FAPT who require a completed SOEI on file.
  - Policies and Procedures- One observation noted that the current policy regarding placement of foster care youth in Psychiatric Residential Treatment Facilities had not been updated to align with recent changes in IV-E regulations.
  - Copay Collection- It was reported that there will be an audit finding regarding the copayment policy and procedures. The auditor indicated that local CSAs are required to

collect assessed copayments. Additionally, Frederick County expenditures are not reflected accurately in the submitted data, as gross expenditures are required. CPMT will be expected to develop a new policy to include collection procedures.

- Strategic Plan Goal- Satisfaction survey subcommittee- Participants are scheduled to meet on October 31, 2022, at the CSA Conference.

New Business:

- Case Support Policy Revision- Robin Hockman, Northwestern CSB requested a policy revision to allow funding for case support on CSA cases where the CSB is the primary agency and case management is not being reimbursed by Medicaid. Jerry Stollings made a motion to cover funding for Case Support to Northwestern CSB for those cases that are not covered by Medicaid or private insurance, Jay Tibbs seconded, CPMT approved.
- Report to SEC- OCS distributed a report discussing recruiting and retaining Parent Representatives on CPMT and FAPT and Best Practices to elevate parent voices in those teams.
    - OCS collected responses from an emailed survey and provided them to the SEC. Ninety-three out of 130 localities, 84 unique, responded to the survey. Of those respondents, 75% were CSA Coordinators, 14% were CPMT Chairs, and 11% were in other roles.
        - 81% of FAPTs and 77% of CPMTs have a Parent Representative on the team.
        - 75% of those Parent Representatives have lived experience.
        - Top recruitment strategies were reported in the "other" category and included "Word of Mouth," "Direct Parent Recruitment," and "Through the FAPT."
        - Top challenges to recruitment were time, role clarity and preparation, and financial.
    - Best Practices in Elevating Parent Voice- Family Engagement is recognized as the national standard for best practice, and integral in the ideal model of service delivery. Research has shown that families who have higher levels of participation in developing their service plans and goals have better outcomes and are more likely to maintain success over time. The guidance offers five standards on how the parent's and family's voices can be strengthened which will be discussed further during future CPMT meetings.

Informational Items:

- None

Assigned Tasks:

- The CSA Coordinator will work with Denise Acker to update the rate sheet for the Case Support service for Northwestern CSB.
- The CSA Coordinator will gather copayment information from other localities to assist CPMT in developing procedures to collect a copayment for services.

Next Meeting: The next CPMT meeting will be held Monday, November 28, 2022, at 1:00 pm in the 1st Floor Conference Room. Dr. Michele Sandy indicated that she will not be available.

Adjournment: Jay Tibbs made a motion to adjourn, David Alley seconded, and the motion was approved. The meeting was adjourned at 2:30 pm.

Minutes Completed By: Robbin Lloyd

Frederick County CSA Financial Update: September 2022

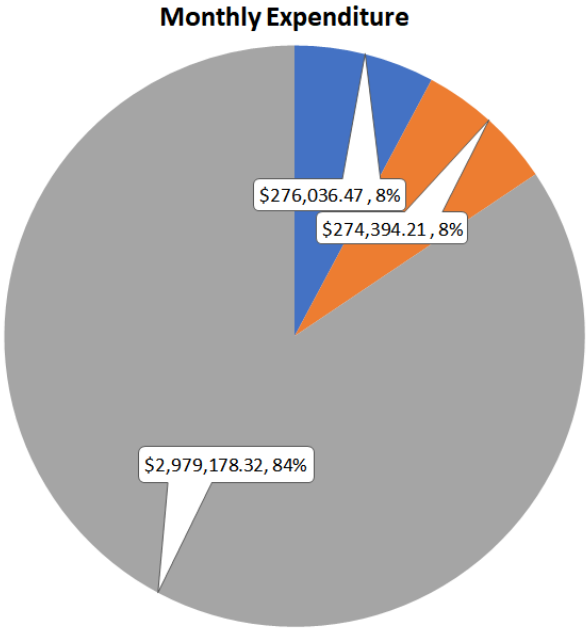
of Reports Submitted: 2

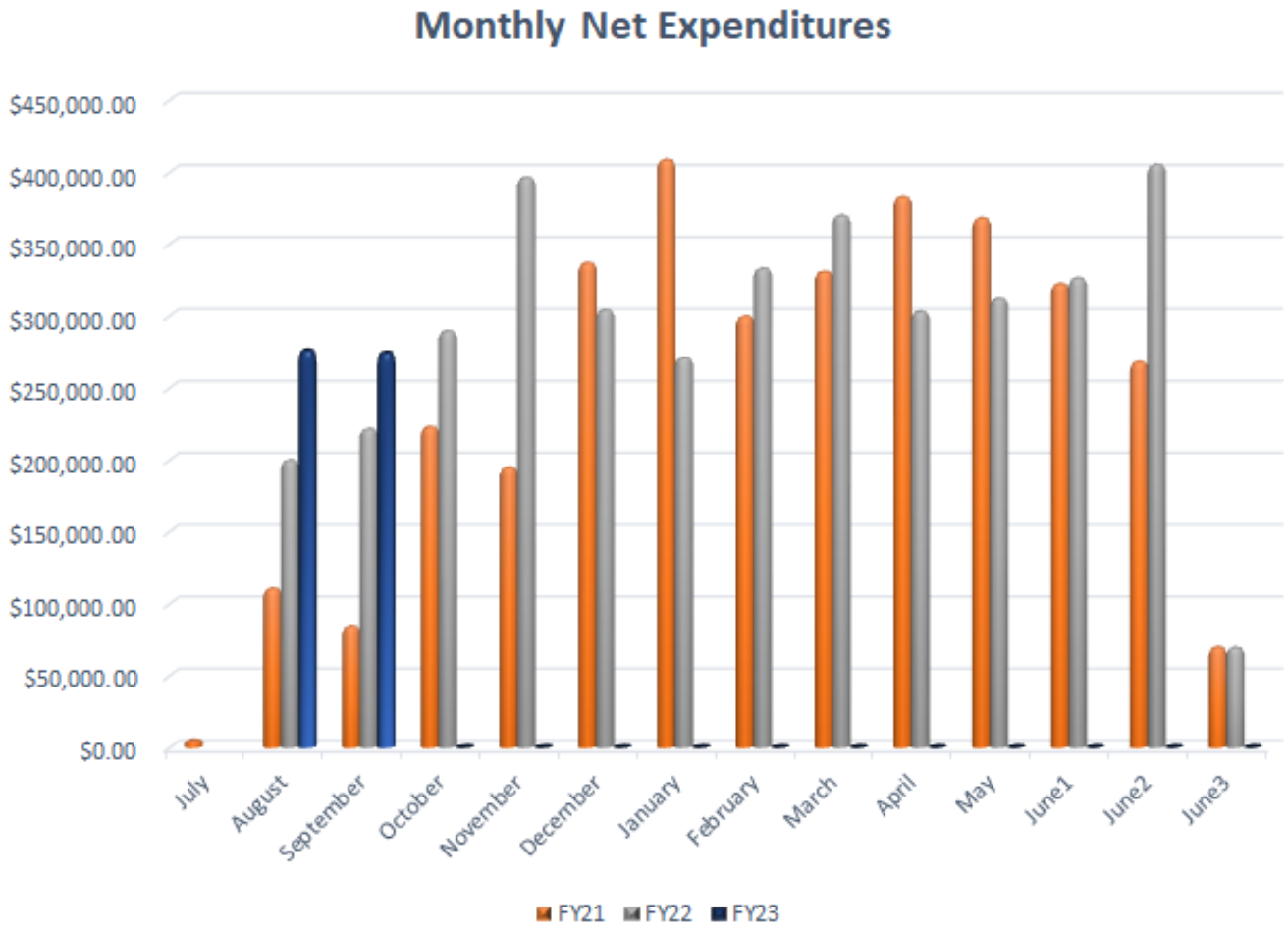
YTD Total Net Spent with Wrap: $550,430.68- 16%

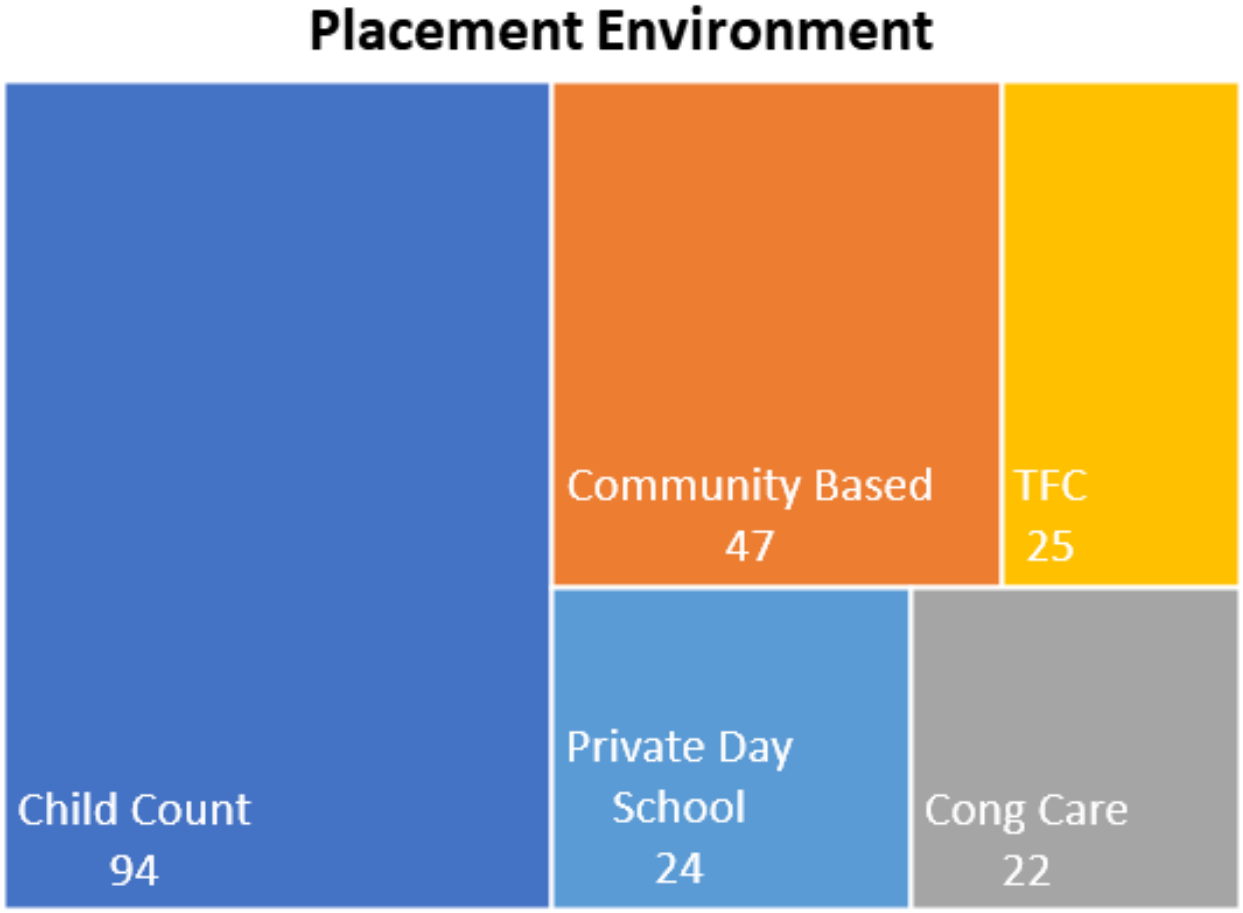
YTD Local Net Expenditures: $213,590.77

Total Remaining: $2,979,178.32- 84%

Remaining without Wrap: $2,979,178.32

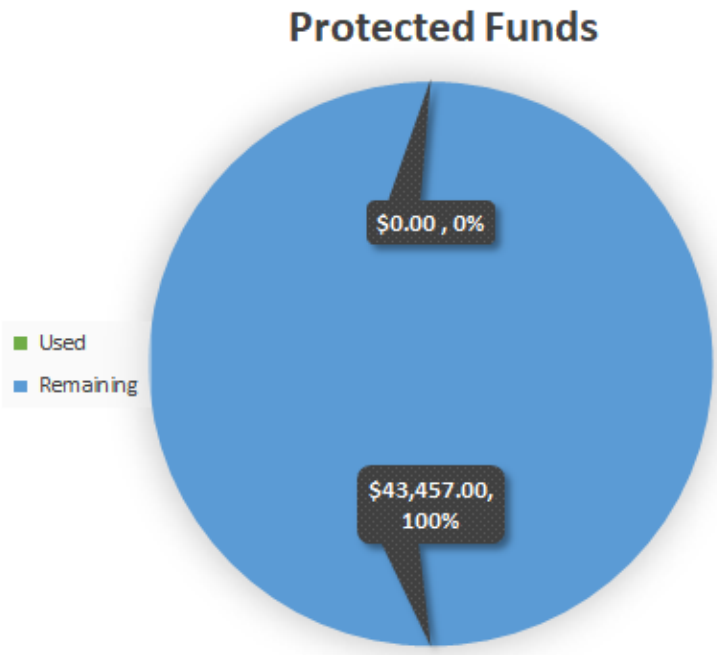


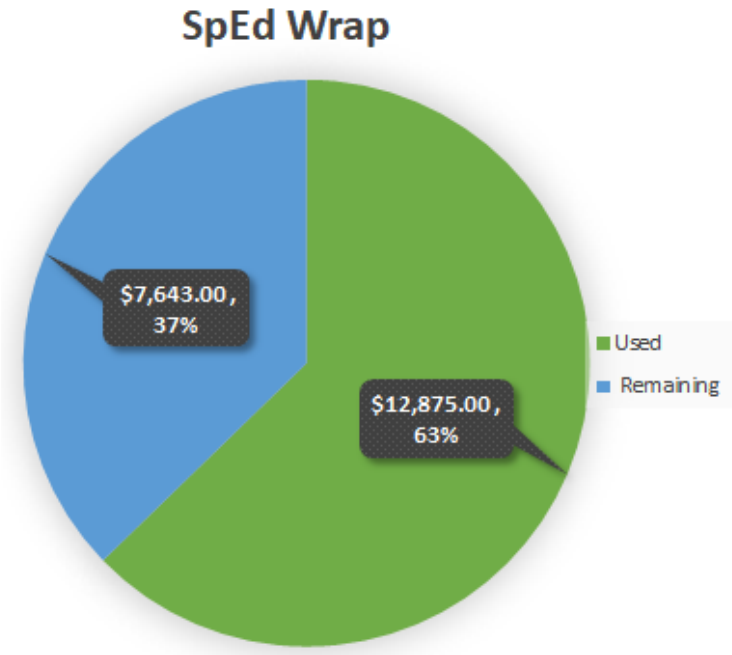




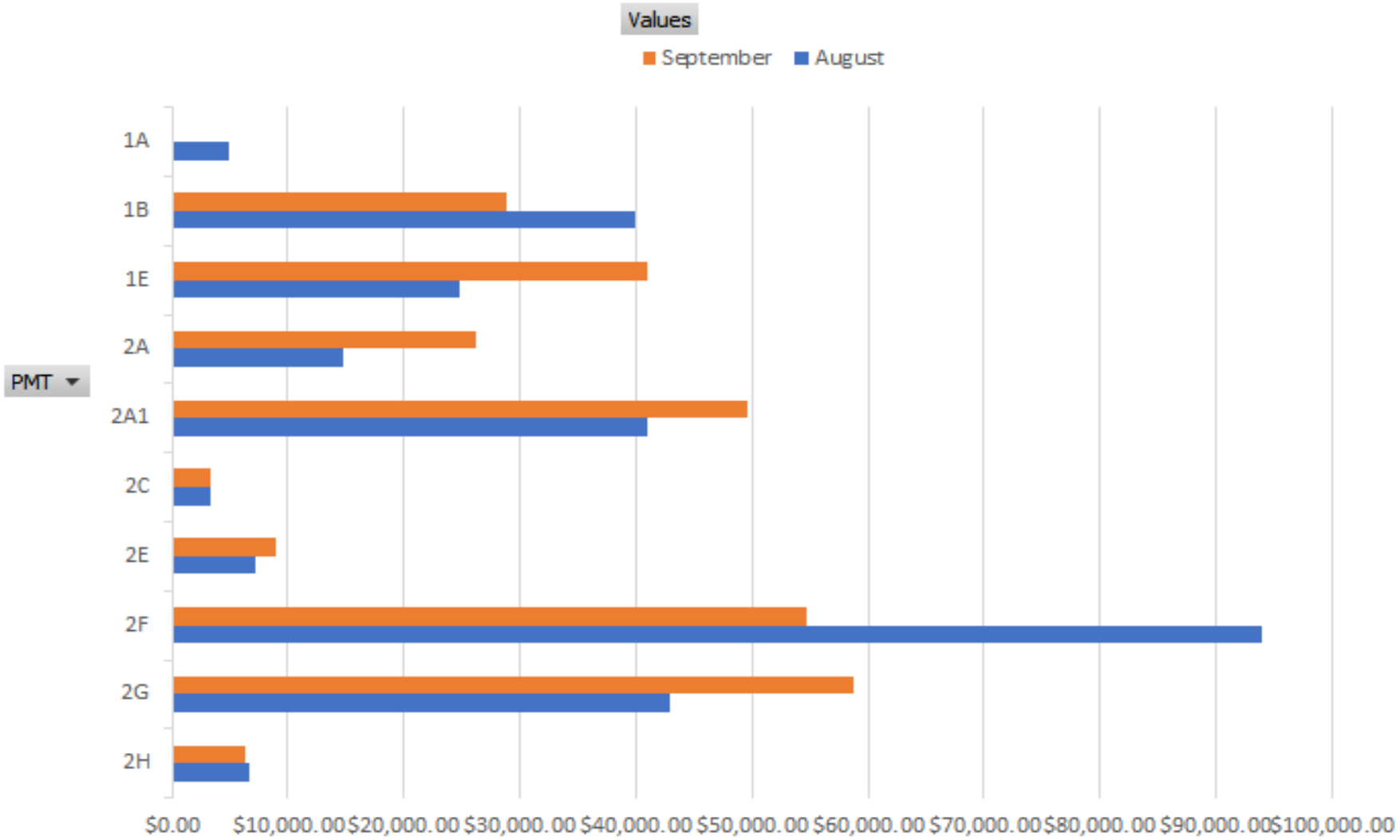
Unduplicated: Child Count, Congregate Care, Therapeutic Foster Care, Community Based Services

*Possible duplication of Private Day School students with youth in Congregate Care





Primary Mandate Type Expenditures by Month



Primary Mandate Types (PMT):

1A- IV-E Congregate Care
1B- Non IV-E Congregate Care
1C- Parental Agreement Congregate Care
*PMTs from 1A-1C do not include Daily Education payment of congregate care placements

1E- Residential Education
*Includes all services for RTC IEP and Education only for all other RTC placements

2A- IV-E Treatment Foster Home
2A1- Non IV-E Treatment Foster Home
2A2- Parental Agreement Treatment Foster Home

2C- IV-E Community Based Services
*Only for youth placed in CFW Foster Homes

2E- Maintenance and Other Services
*Only Basic Maintenance and Daycare for youth in Foster Care

2F- Non IV-E Community Based Services
*Includes Daycare for youth not in Foster Care or IV-E CBS for youth placed in TFC or Cong Care

2G- Private Day School

2H- Special Education Wrap Around Services

3- Protected Funds
*NonMandated

CSA Program Improvement

Summary of Discussion

10/31/22

Present: Michele Sandy, Dave Alley, Jerry Stollings, Jackie Jury
Next meeting: TBD

1. Discussion

Who, What, When, Where, Why, & How- The 3rd Strategic Goal, to develop a satisfaction survey for the purpose of improving the CSA program was discussed. To further define "improving the CSA program", participants brainstormed about ways to collect data that can be used to identify and prioritize those areas needing improvement. The discussion identified several categories that should be considered including whose input was necessary, what information should be collected, and what was the best method to obtain the information.

2. Steps Considered

Gather 5 stakeholder focus groups- 4 Agency specific and 1 Judges

Conduct Question & Answer session with each group

Review and analyze data collected

Prioritize areas of improvement

This data can then be used to direct the development of surveys for a larger group, identification of future strategic goals, reconsideration and/or revision of current policy, and implementation of new initiatives.

3. Tasks

Create shared document for participants to develop questions for focus groups
Completed 11/21, Jackie Jury

Identify individuals to participate in stakeholder focus groups- 5-6 from each agency
Target Date 11/28/22, CPMT

Schedule focus groups
Target Date 2/28/23, Dave Alley & Jerry Stollings

Copayment Process Review

Note: The commonwealth is currently forming a workgroup to develop a standard template for copayments, but it would only be a reference type document.

Wythe- Copay sent to DSS payable to Wythe Cty CSA. Finance provide copy of payment and receipt provided to family to CSA for records.

Suffolk/Isle of Wight- For families who have been assessed a copayment, CSA reviews cases monthly to determine if services were provided. Invoices are sent out. Collected copayments are sent through finance. CSA keeps track of any non-payments and are warned several months in advance. If no payment is received, CSA files a tax intercept in December each year. The CSA Coordinator commented that she finds it difficult to keep up with the copayments and gets behind sending out monthly invoices. Out of home placements are referred to DCSE.

Fluvanna- Has a policy that they don't collect a copay. Program Manager commended that his CPMT is philosophically opposed to copayments. Their policy has not been through audit yet.

Page- Assess 3% for CBS and 9% for out of home, have some exemptions. Did not provide actual process.

Hanover- Process is provided as separate document

Parental Co-Payments

1. Initial Assessment

A parental financial contribution (i.e. co-payment) will be determined for all cases unless specifically prohibited by federal or state law or regulation, or has not been ordered by the court or by the Division of Child Support Enforcement (DCSE).

Exemptions from a co-payment:

- Services included on an Individualized Education Plan (IEP).
- Services funded by Medicaid.

Children in the custody of the Department of Social Services will be assessed through DCSE and therefore are not subject to the CSA co-payment assessment.

If a parental co-payment is applicable, the Lead Agency Case Manager (LACM) will inform the parent of the parental contribution to the CSA program when initiating contact with the family.

If parents share in custody equally and there is no child support, both parents will be assessed a co-payment.

The LACM shall provide the parent with the Parental Copayment Agreement form and proof of income requirement.

In the case of a Parental Presentation, the CSA Coordinator will be the contact person for the parent by informing the parent of the parental contribution and providing the Parental Copayment Agreement form as part of the FAPT application, including the proof of income requirement.

Parents will complete the Parental Copayment Agreement (FIW) which shall be returned to the CSA Office for review prior to the initial FAPT meeting. The LACM may assist the family by returning the information to the CSA Office with other case related paperwork (i.e. consent to release).

2. Review of FIW and supporting paperwork

The CSA Office will receive the completed Family Income Worksheet with supporting documentation, as applicable.

- If any areas of the worksheet or supporting documentation are incomplete, the CSA Coordinator will reach out to the family.
- For Parent Presentations, the FAPT meeting will not be scheduled until the complete form and supporting documents have been received.

Exception: If services are of an emergency nature or statutory requirement, as determined by the CSA Coordinator or Hanover Court, the co-payment assessment will be held in abeyance for 15 days to allow for the development of the IFSP and delivery of service identified at FAPT. The

co-payment process and agreement shall be completed within two weeks of the first FAPT. Services may be suspended if the assessment is not completed by the parent.

2.1 In reviewing the paperwork, the CSA coordinator verifies the following regarding eligibility:

- Ensure that the child is eligible for a co-payment and does not fall into one of the exemptions.
- Determine who the parent/custodial parent is and if there should be a co-payment.
- For the purpose of the co-payment, only biological and adoptive parents' income will be assessed.
- The income of extended family members (step-parents, grandparents, aunts, uncles, etc.) providing residence for the child(ren) is waived.
- If a biological parent is absent from the home and retains parental rights, his/her income shall also be subject to a parental co-payment unless the parent is providing verified monthly child support payments.
- If the child is residing approximately equally between parents, and no one is paying child support, both parents will be assessed a co-payment.

2.2 FIW - General Information section

- If the answer to the questions in this section of the worksheet are no, then proceed to the Employment Income section to determine the co-payment amount.
- If any of the questions are answered yes, if applicable, verify the supporting documentation.
- If all of the information is confirmed or not applicable, proceed to the Employment Income section to determine the co-payment amount.
- Additionally, the parent(s)/legal guardian(s) may waive the co-payment assessment process and agree to accept the highest rate; this amount may be re-assessed with documentation of income at a later date.
- If there are any questions or concerns, CSA Coordinator will reach out to the family.

2.3 Determining Co-payment Amount

- The CSA Coordinator will verify that the Parent Income on the worksheet matches the supporting documentation from both the Employment Income section.
- This should include but not limited to pay stubs, statement from employer, tax forms, SSA/SSDI award letter, rental income, retirement, and unemployment compensation award letter.
- Calculate the annual gross income including any amounts from the Other Monthly Income section.
- Using the locally developed sliding fee scale and the annual gross income will provide the community based assessment rate.

$ 0 - $ 20,000	= 0
$20,001- $ 30,000	= $ 25
$30,001- $ 50,000	= $ 50
$50,001- $ 70,000	= $ 75

$70,001- $100,000	= $ 100
$100,001 - $150,000	= $ 150
$150,001 - $200,000	= $ 200
$201,000 +	= $ 300

- The residential assessment rate shall be established at twice the community based assessment rate.
    (1) CSA Office Use Only

        The CSA Office will complete this section by entering the information obtain from the support documentation.

        Any notes about the calculation or case may also be entered in this section.

3. Parental Copayment Determination Letter and Thomas Bros Set-Up

The Parental Copayment Determination Letter will outline the community and residential rates for services and the billed amount will fluctuate between the pre-assessed rates depending on the services recommended by FAPT in the ISFP.

The co-payment rate shall be effective on the date of the first FAPT, or when services are authorized to begin.

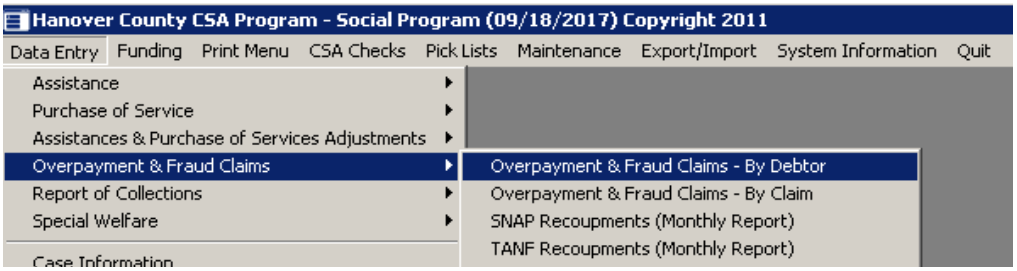
After the initial FAPT meeting, the Parental Copayment Determination letter will be sent to the family.

The CSA Office will scan a copy of the Parental Copayment Agreement, Parental Copayment Determination Letter and any supporting documentation and save on the T drive. The original forms will be sent to Finance to maintain in the co-payment files.

Upon receiving the original PCA, the CSA Financial Technician will create a new entry in Thomas Brothers.

3.1 <u>Creating Debtor in Thomas Brothers</u>

Select Data Entry – Overpayment & Fraud Claims – Overpayment & Fraud Claims – By Debtor.



Click the Add button in the top ribbon.

Select the Vendor overpayment/fraud or Parental Co-Payment button.

(1) Select the Vendor from the drop-down menu. If the parent is not in the list, then the information will need to be added.
(2) Select Add for a new vendor. Enter the information in the Vendor Information screen. The Tax ID number will be 000-00-CSA #.
(3) Save.

(4) Click OK.
(5) In the Notes tab, select Add Note.
(6) Enter the date of the assessment.
(7) Enter the subject as Assessment.
(8) Enter the community based rate and residential rate in the Note field.
(9) Save.

4. Invoicing

The CSA Office will provide monthly invoices to the parent(s). All parental co-payments will be paid directly to the CSA Office and are due by the 20th of the following month.

Monthly invoices shall be pro-rated to reflect the dates and types of services when initiating services and transitioning between levels of care only.

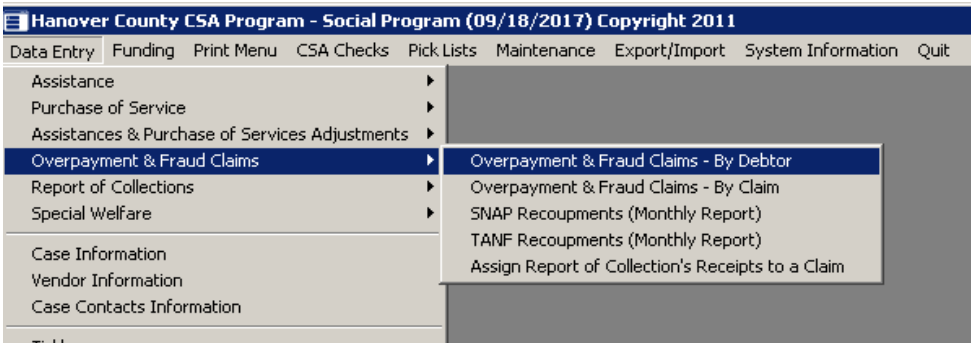
For example, the initial invoice shall be prorated for the dates of authorized services, if a child enters residential program half way through the month, the copayment will reflect a portion of community based services and a portion of the residential rate. If the service provider is adjusted and there is a gap in services, the co-payment amount will not be adjusted for days in which the service is not provided.

The Parental co-payment amount shall not exceed the cost of services rendered.

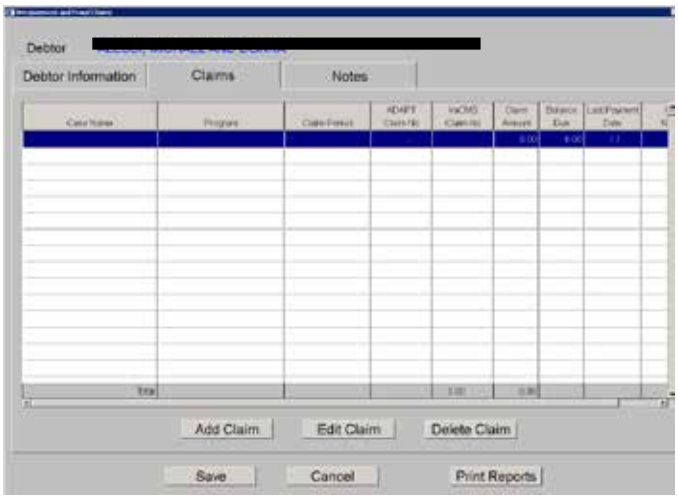
4.1 The CSA Technician creates invoices on a monthly basis per the following steps:

4.1.1 Create a Claim in Thomas Brothers

Select Data Entry – Overpayment & Fraud Claims – Overpayment & Fraud Claims – By Debtor.



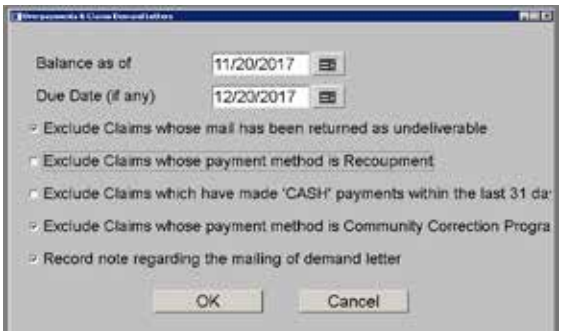
(a) Select the parent(s)/legal guardian(s) name.
(b) Select the Claims tab at the top of the screen.
(c) Click on the Add Claim.



(d) The Claim data entry screen will open.
(e) The Claim Date will usually be the 20th of the month or the closest business day.
(f) The Claim Amount is the monthly co-payment amount.
(g) The Program Type is Parental Copayments and the FIPS remains as 085 Hanover County.
(h) Select Co-payment from the Claim Type.
(i) The Claim Period is the beginning of the month year and ending of the month year.
(j) Select the Case Name associated with the Debtor.
(k) If a note needs to be visible on the invoice, enter it in the Demand Note field.
(l) Save once all fields are filled.
(m) Repeat these steps for each co-payment.
(n) Once all co-payment information has been entered for the month, exit the Overpayment & Fraud screen.

4.1.2 Printing Invoices in Thomas Brothers

(a) Select Print Menu – Overpayment & Fraud Claims – Overpayments & Claims Demand Letters.
(b) In the popup screen, enter the invoice date as the Balance as of date and the due date for 30 days later.



(c) Uncheck Exclude Claims whose payment method is Recoupment and Exclude Claims which have made 'CASH' payments within the last 31 days.
(d) Check the box for Record note regarding the mailing of demand letter.

(e) This will create a note in the Overpayment & Fraud Claims.
(f) Select Ok.
(g) Choose Select All and Ok.
(h) Preview the file and save a copy as a pdf on the S drive.

Email a copy of the pdf to the CSA Coordinator to confirm that the amounts are accurate based on the services provided for that month.

Once the CSA Coordinator approves, the invoices will be mailed out on the 20th of the month.

5. Payments and Collections

The CSA Office will provide monthly invoices to the parent(s). All parental co-payments will be paid directly to the CSA Office and are due by the 20th of each month following the month of service billed.

All payments will be processed as recoveries to CSA pool funds and will be collected in accordance with the Hanover County Revenue Policies.

If a parent expresses an inability to pay the co-payment amount determined by the financial assessment, they will be allowed to provide an amount, no less than 50% of the determined amount, that they will pay each month. As long as the parent is paying at least this amount each month, then their account will not be considered delinquent. However, this reduced monthly amount does not reflect a reduction in the co-payment responsibility; instead, it provides a way for the parent to meet this obligation without undue financial burden. The parent will continue to incur the full monthly expense. Moreover, they may continue to have financial obligations to Hanover CSA after services have ended.

5.1 Delinquent Accounts

If parent(s)/legal guardian(s) choose not to submit the monthly parental co-payment, as assessed or adjusted, the Hanover CSA Office will initiate the following delinquent payment procedures as established by CPMT:

A 60 Day Past Due letter, signed by the CSA Coordinator, will be sent to the parent(s) indicating that the parental co-payment is past due and requesting that the payment be made in full.

A 90 Day Past Due letter, signed by the Fiscal Agent (CSA Accountant), will again offer an opportunity for the payment to be made in full. This letter will also set forth that if such actions are not made, and the account reaches 90 days past due, the delinquent account may be submitted to the Hanover County Treasurer's Office, which will initiate collection activity.

Once an account is 120 days or more past due and has reached a minimum threshold of $100.00, a letter, signed by the Chair of the Hanover CPMT will be sent to the parent indicating that the delinquent account is being submitted to the Hanover County Treasurer's Office for collection activity to be initiated.

Finance recommends to CPMT that accounts over 150 days past due be sent to the Hanover County Treasurer's Office for collection activity to be initiated. This is first presented to CPMT for discussion as noted in section 6.

Upon approval by CPMT, the CSA Financial Technician will prepare a delinquent letter for the Fiscal Agent to review and sign.

If any past due accounts more than 150 days past due and $200.00 or less in which the youth is no longer receiving CSA-funded services will be written-off.

A letter will be sent to the parent(s) and signed by the Fiscal Agent communicating that the balance was written-off.

When the signed letters are returned to the CSA Financial Technician, they are scanned to the T drive.

The 60- and 90-day letters will be mailed. The 120-day letter will be sent by both certified and first class mail.

In the Notes tab of the Overpayment & Fraud Claims, select Add Note.

(1) Enter the date the letter was mailed.
(2) Enter the subject as 60/90/120/Delinquent Letter.
(3) Enter the outstanding balance. For Delinquent Letters also enter the date CPMT approved sending to Collections.
(4) Save.

5.2 Collections

Upon approval by CPMT, the CSA Financial Technician will prepare a delinquent letter for the Fiscal Agent to review and sign. The letter will set forth that if payment is not received within two weeks, the balance specified will be submitted to the Hanover County Treasurer's Office initiating collection activity. This will include a $25 fee for collection activity.

The CSA Financial Technician will scan a copy of the letter to the T drive and mail.

On the date indicated in the letter, the Fiscal Agent (CSA Accountant) will send a spreadsheet to the Treasurer's Office. The spreadsheet contains the parent(s)/legal guardian(s) name and address, dates of the 60, 90, 120 and delinquent letters, and amount CPMT approved to be submitted for collections.

The CSA Financial Technician will enter an adjustment in Thomas Brothers for each outstanding amount in the Overpayment & Fraud Claims – By Debtor in the Adjustment tab.

In the Notes tab of the Overpayment & Fraud Claims, select Add Note.

(1) Enter the date the email was sent to the Treasurer's Office.
(2) Enter the subject as Treasurer's Office.
(3) Enter the outstanding balance and date CPMT approved sending to Collections.

(4) Save.

6. Monthly Aging Report and CPMT Communication

The CSA Financial Technician prepares a Monthly Aging Report spreadsheet for parental co-payments. The spreadsheet contains the case name, monthly co-payment amount, amount paid in the current fiscal year, amount of co-payments that are current, 30 days, 60, days, and over 90 days outstanding, a total for each case, date of last assessment, notes and recommendations from Finance.

Once updated, the spreadsheet is reviewed by the Fiscal Agent prior to sending to CPMT.

6.1 CPMT

CPMT reviews the parental co-payment accounts on a monthly basis.

CPMT approves write-offs of any outstanding account balances based on case history, length past due, and whether the youth is still receiving CSA services, except for items falling within the guidelines for 120 Days Past Due noted above.

CPMT approves submission of past due accounts to the Treasurer's Office for collections.

6.2 Reassessment

As financial circumstances change over time, each family will complete a reassessment of the parental contribution at least annually. The CSA office, in cooperation with the LACM, will provide the parent with the Parental Copayment Agreement to complete with updated/ current information.

A family may request a re-assessment in the event of financial changes to include, employment changes, loss of income, application for services or changes in custody arrangements.

The CSA Financial Technician will enter a note in the Overpayment & Fraud Claims screen with the date the new Family Income Worksheet is received.

The new community based rate and residential rate will be entered in the Note field along with the effective date.

The new rates will begin on the effective date, which may cause a pro-rated co-payment for the month.

Medicaid & IACCT Policy Revision Proposal

3.2.1.3 Independent Assessment, Certification, and Coordination Team

Medicaid eligible children and youth needing services in a Psychiatric Residential Treatment Facilities (PRTF) or Therapeutic Group Homes (TGH) must be evaluated through an Independent Assessment, Certification and Coordination Team (IACCT) to meet medical criteria for that level of care.

Continued Stay Review- The completion of an IACCT evaluation is not necessary for Continued Stay Review. Providers must submit required Medicaid documentation within established timelines for authorization of services to continue beyond the initial approval period. Denial of services by Medicaid does not obligate the use of CSA funds. Services denied due to failure of the provider to meet Medicaid requirements and timelines will not be reimbursed by CSA. Services denied due to the enrollee not meeting medical criteria may be funded by CSA for up to 30 calendar days, excluding State and Federal Holidays.

3.2.1.3.1 Introduction

Effective July 1, 2017, the Virginia Department of Medical Assistance Services (DMAS) implemented new regulations (12VAC30-50-130) which involved major changes to the Psychiatric Residential Treatment Service Program (~~current~~ formerly Medicaid Level C and Level B placements). Included in these changes is the establishment of a revised process for determining if a Medicaid-eligible child meets medical necessity criteria and issuing the Certificate of Need required for Medicaid funding of such placements. DMAS and ~~Magellan of Virginia, DMAS'~~ its contracted Bbehavioral Hhealth Sservices Aadministrator (BHSA), currently Magellan of Virginia, have developed relevant guidance and training regarding how these new practices, known as the Independent Assessment, Certification and Coordination Team (IACCT), will function.

This document is intended to provide guidance regarding the ~~Frederick County CSA~~ interface between Frederick County CSA's FAPT/CPMT processes under the Children's Services Act (CSA) and the DMAS/~~Magellan~~the BHSA IACCT process. This document will address workflow, decision making authority, and fiscal responsibility. **Note: the authority to obligate CSA funds is in all cases retained by the Frederick County CPMT. DMAS/~~Magellan~~the BHSA, through the IACCT process, in all cases retains authority to obligate Medicaid funds to pay for the covered components of such placements.**

3.2.1.3.2 Children in Custody of the Local Department of Social Services

All placements of children in the custody of an LDSS will be initiated by the LDSS as the legal guardian through established VDSS regulations and policies as well as Frederick County CSA policies governing "emergency" and "non-emergency" placements. As the legal guardian, LDSS will be expected to participate in the defined IACCT processes in addition to the current FAPT requirements. The funding source (Medicaid, IV-E, or CSA) of Room & Board and Daily Supervision follows regulations set by Medicaid and/or IV-E regarding cost sharing and the use of a QRTP.

3.2.1.3.2.1 Non-Emergency Placements

These are children in the custody of an LDSS who are presently in a viable foster care placement [family foster home, treatment foster care, or other setting where they can be safely assessed and reside (e.g., psychiatric hospital, juvenile detention center)] and for whom the LDSS is recommending a placement change to a psychiatric residential treatment facility (PRTF) or therapeutic group home (TGH).

- If the child's Medicaid eligibility is already established, the LDSS family service worker will initiate the IACCT process upon determination that a PRTF or TGH is necessary, by completing the Residential Request form located on the ~~Magellan of Virginia~~BHSA website. ~~After submitting the form~~Concurrently, the case manager will contact the CSA Office to have the case reviewed by the Family Assessment and

Planning Team (FAPT) for consideration through established LDSS and CSA local policies. The LDSS family service worker should collaborate, to the extent possible with the IACCT on the recommendation for residential or alternate community-based services.

- If the FAPT process and the IACCT results in a recommendation and approval of a residential placement:
    - funding will be authorized as under current practice, with CSA responsible for the educational costs and Medicaid covering the treatment services. ~~For PRTF placements, room and board and daily supervision costs are either billed directly to the LDSS (if the child is Title IV-E eligible) or included in the Medicaid billing if the child is not Title IV-E eligible).~~ For foster children placed in a TGH, room and board are paid either through Title IV-E or CSA, as room and board in such facilities is not a Medicaid covered expense.
    - the local Medicaid match is collected by the Office of Children's Services (OCS) for transmittal to DMAS.
- If the IACCT issues a Certificate of Need, but the FAPT does not recommend the placement, no CSA funds may be used.
- If the child's Medicaid eligibility has not yet been established (or is suspended due to a placement in a juvenile detention setting or commitment to the Department of Juvenile Justice), the Frederick FAPT and Community Policy & Management Team (CPMT) will review on a case by case basis the cost of the treatment services pending the Medicaid eligibility determination (or reinstatement), at which time eligibility is made retroactive to the date the child entered LDSS custody or had Medicaid eligibility reinstated. If the child in LDSS custody is determined to be ineligible for Medicaid (e.g., child is undocumented for immigration purposes, child has parental resources that make them ineligible for Medicaid), CSA will be fully responsible for the cost of CSA approved placements. These children will ~~need to~~typically be assessed by the CSA team prior to referral to the IACCT, as they are not yet Medicaid eligible. Alternatively, they may fall under the "Emergency Placement" provisions found below.
- If Frederick County FAPT and CPMT approves the placement, but the IACCT does not approve a PRTF or TGH level of need, CSA is authorized to cover the full cost of the placement for up to ~~15~~ 30 ~~business~~ days, excluding State and Federal holidays. The FAPT/CPMT/Agency should work with the IACCT and ~~Magellan~~the BHSA to determine and arrange the appropriate services to meet the child's needs and an alternative to residential placement should be implemented as soon as practicable.
    - Room and board and daily supervision costs are either billed directly to the LDSS [(if the child is Title IV-Eeligible (TGH only)]~~)~~ or to CSA.
    - the local Medicaid match will not be collected by CSA as Medicaid will not be paying for any part of the placement.
    - Frederick County CSA Office will report on these cases (Certificate of Need not authorized by the IACCT) to the OCS using a standard format. The purpose of such reporting is to establish data on the number and reasons for such outcomes in order to improve the service continuum. (Note: The details for this reporting is described in a separate document).
    - If a child in foster care is ordered by the court to be placed in a congregate care setting (TGH or PRTF), the CSA shall cover the full cost of the placement in accordance with the court order, even if the IACCT does not authorize the placement.
    - Frederick County CSA Office will report on these cases (Certificate of Need not authorized by the IACCT) to the OCS using a standard format. The purpose of such reporting is to establish data on the number and reasons for such outcomes in order to improve the service continuum. (Note: The details for this reporting is described in a separate document).

- If the child is placed in a non-Medicaid facility in accordance with established CSA requirements for the use of non-Medicaid facilities, the CSA would be fully responsible for the cost of the placement and no approval from IACCT is required. Documentation on the Individual Family Services plan (IFSP) regarding use of a non-Medicaid facility ~~will be documented on the Individual Family Services plan (IFSP) a~~is required for CSA purposes.

3.2.1.3.2.2 Emergency Placements

These are children in the custody of an LDSS who are in immediate need of placement in a PRTF or TGH and who do not meet the criteria to receive crisis intervention, crisis stabilization or acute psychiatric inpatient services and require emergency placements in residential or group home programs. These are defined in the DMAS regulations as "emergency admissions" or "placements". Such "emergency placements" may be authorized under the CSA (§2.2-5209) for up to 14 days at which time the "routine" FAPT and CPMT approval processes must occur. The circumstances under which the LDSS initiates an emergency placement or admission are the same as under current CSA and LDSS practice. Emergency placements in residential facilities for children in foster care should generally be an action of last resort after other less restrictive placements are explored and ruled out.

- According to 12VAC30-50-130, the Certificate of Need for such emergency admissions shall be completed by the facility-based team responsible for the child's plan of care within 14 days of admission and submitted to ~~Magellan~~the BHSA. The certification shall need to cover the full period of time after admission and before for which claims are made for reimbursement by Medicaid. Within five days of admission, the facility admitting a foster child under the "emergency placement" process shall work with the legal guardian (LDSS) to refer that child to the IACCT in the locality where the LDSS holds custody, but the Certificate of Need will be completed by the facility team, not by the IACCT.
- All children placed in a PRTF or TGH under LDSS/CSA emergency placement authority shall immediately be referred by the LDSS family service worker to the Family Assessment and Planning Team (FAPT) for consideration through established local CSA practices.
- If the child is placed in a non-Medicaid facility in accordance with established CSA requirements for the use of non-Medicaid facilities, the CSA would be fully responsible for the cost of the placement and no approval from IACCT is required. Documentation on the Individual Family Services plan (IFSP) regarding use of a non-Medicaid facility ~~will be documented on the Individual Family Services plan (IFSP) a~~is required for CSA purposes.
- Once the child is referred to the FAPT/CPMT and the placement is no longer under the "emergency" provisions (i.e., after 14 days following the placement), the same guidance as applies to "non-emergency" placements of children in LDSS custody will apply. Reauthorization for Medicaid funding after the Certificate of Need for the initial emergency admission will be pursuant to the established ~~Magellan~~BHSA procedures and criteria.

3.2.1.3.3 ~~3.2.1.3.3~~ Students with Education Disabilities Placed Pursuant to an Individualized Education Program (IEP)

- Students placed in PRTF residential facilities due to this setting being specified as the Least Restrictive Environment (LRE) on their IEP shall be referred to FAPT and/or CPMT for funding of such placements according to local CSA policy.
- If the child is Medicaid eligible at this time, the parents/legal guardian should be asked (and assisted as needed) to make a self-referral to the local IACCT to determine if the child meets medical necessity criteria which would (potentially) allow the treatment component of the placement to be paid by Medicaid. Parents/legal guardians of students placed for educational reasons cannot be compelled to be referred to IACCT as they are entitled to a free and appropriate public education independent of any utilization of Medicaid funds to support such placements. If the child is also in foster care, the LDSS shall make a referral to the IACCT in their role as legal guardian.

- When the parent/legal guardian agrees to a referral to IACCT:
    - if the IACCT process results in an approval of a placement with Medicaid funding due to existing medical necessity criteria:
    - funding would be authorized as under current practice, with CSA responsible for the educational costs and Medicaid covering the treatment services. If the child is also in foster care, room and board and additional daily supervision would be billed as for a foster child (Title IV-E, CSA, or Medicaid).
    - the local Medicaid match is collected.
    - no parental contribution can be assessed.

  The IEP remains the governing authority for the placement. If at any time, ~~Magellan~~the BHSA/DMAS discontinues authorization for the placement, CSA will become fully responsible for the cost of the placement as long as the IEP remains in effect with residential placement as the LRE.

  If the child is placed in a non-Medicaid facility (including those designated exclusively as residential schools and not psychiatric treatment facilities) in accordance with the IEP, the CSA would be fully responsible for the cost of the placement and no approval from IACCT is required. Documentation regarding use of a non-Medicaid facility will be documented on the Individual Family Services plan (IFSP) as required for CSA purposes.

  If the parent/legal guardian declines to refer to IACCT or the IACCT determines that the child does not meet medical necessity criteria, CSA shall be fully responsible for the full range of costs associated with the educational placement.
    - If the IACCT does not authorize the level of care, the local CSA will report such cases to the OCS using a standard format. The purpose of such reporting is to establish data on the number and reasons for such outcomes in order to improve the service continuum. (Note: The details for this reporting is described in a separate document).

  Children currently served by CSA through an IEP for private day educational services, may at times, be placed directly by their parents in a residential treatment setting for non-educational reasons (i.e., the placement in the residential setting is not the least restrictive environment specified on the child's IEP). In such instances, the private day education becomes "functionally unavailable" and the cost of the child's educational services in the residential setting becomes the responsibility of the CSA. The cost of the child's non-educational services (treatment) in the residential setting is not the responsibility of CSA and will be funded via Medicaid, as appropriate or the parent. CSA may review and consider whether the child meets criteria for a CSA Parental Agreement, see CHINS/CSA Parental Agreement and Non-Mandated Children section below. The local Medicaid match will be collected for children with private day IEPs placed in residential settings by their parents as these are considered CSA cases.

3.2.1.3.4 Child in Need of Services/CSA Parental Agreement and "Non-Mandated" Children

Note: This section refers to children who have already come through the CSA process for eligibility and service planning processes.

- If the child is Medicaid eligible, Frederick County CPMT requires that all CSA Parental Agreements for Medicaid eligible children be referred to the IACCT for consideration for Medicaid funding. This is consistent with OCS requirements that Medicaid funding shall be utilized when possible. Frederick County CPMT requires that CSA Parental Agreements for residential placements for Medicaid-eligible children are contingent on completion of the IACCT process and an approval for Medicaid funding of the applicable components of the placement (i.e., treatment and room and board).
- Once the referral to IACCT has been submitted, FAPT will convene to determine eligibility as a Child in Need of Services (CHINS) or as a CSA-eligible "non-mandated" child in accordance with existing CSA

and local CPMT policy. Once eligibility for CSA has been established, the FAPT then determines (and the CPMT approves) if placement in a TGH or PRTF facility is appropriate and initiates a CSA Parental Agreement.

- If the IACCT process and FAPT recommendation results in an approval of the placement:
  - funding would be authorized as under current practice, with CSA responsible for the educational costs and Medicaid covering the treatment services. For PRTF placements, room and board costs are included in the Medicaid billing. For children placed in a TGH therapeutic group home, room and board is paid through CSA as room and board in such facilities is not a Medicaid covered expense.
  - the local Medicaid match is collected.
  - Child Support under the Division of Child Support Enforcement will be assessed and collected.
- If the child is placed in a non-Medicaid facility in accordance with established CSA requirements for the use of non-Medicaid facilities, the CSA would be fully responsible for the cost of the placement and no approval from IACCT is required. Documentation regarding use of a non-Medicaid facility will be documented on the Individual Family Services plan (IFSP) as required for CSA purposes.
- If the IACCT process or FAPT recommendation does not result in approval of the placement:
  - Frederick County CPMT does not authorize funding to cover the full cost of the placement.
  - The FAPT/CPMT should work with the IACCT and ~~Magellan~~the BHSA to determine and arrange appropriate services to meet the child's needs and arrange an alternative to residential placement as soon as practicable.
  - if the child is determined to be a Child in Need of Services (CHINS) via a court finding and the court order is for residential treatment, the CSA shall cover the full cost of the placement in accordance with the court order.
  - the local Medicaid match will not be assessed as Medicaid will not be paying for any part of the placement.
  - the local CSA will report cases in which the Certificate of Need not authorized by the IACCT to the OCS (OCS) using a standard format. The purpose of such reporting is to establish data on the number and reasons for such outcomes in order to improve the service continuum. (Note: The details for this reporting is described in a separate document).

3.2.1.3.5 Medicaid Eligible Children Referred Directly to IACCT

- Parents/legal guardians of Medicaid eligible children not previously described in this document may be referred to IACCT without current involvement in the CSA process. Such children may be referred by other service providers, a residential facility, or directly by the parent.
- In such cases, the DMAS regulations and ~~Magellan~~the BHSA workflow require that, with the parent's consent, the IACCT will notify the local CSA office. ~~CSA eligibility determination and service planning will occur according to state and local CSA policies.~~ The contracted IAACT provider, will obtain the necessary consent forms and notify the CSA Office within 24 hours of completion of the assessment. CSA eligibility determination and service planning will occur according to state and local CSA policies.
- The Frederick County CSA Coordinator will follow the current Parental Referral procedure in accordance with the local CPMT policies.

3.2.1.3.6 Children Eligible for Medicaid after 30 Days in Placement ("Family of One" Eligibility)

The DMAS regulations (Psychiatric Services Supplement A (page 19) specify that:

"All individuals entering psychiatric residential treatment care utilizing private medical insurance who will become eligible for enrollment in the state plan for medical assistance within 30 days following the facility admission are required to have an independent certification of need completed by the team

responsible for the plan of care. The facility will provide the certificate of need using the facilities treatment team within 14 days from admission.

Upon the individual's enrollment into the Medicaid program, the congregate care facility or IMD shall notify the BHSA of the individual's status as being under the care of the facility within 5 days of the individual becoming eligible for Medicaid benefits to begin the coordination and assessment process by the IACCT."

- For children who are already known to CSA as described elsewhere in this guidance document, the FAPT should upon authorizing, recommending or making an IACCT- approval contingent placement through CSA, gain parental consent for the case manager to refer the child to the IACCT upon becoming Medicaid eligible as specified in the regulations. Parents should be advised that if they wish to avail themselves of the Medicaid benefit after 30 days in placement, this is a requirement of the state Medicaid program. Guidance provided in this document is applicable to these situations, depending on the CSA eligibility category of the child.
- If a family refuses to seek Medicaid eligibility, then the family will become solely responsible for the placement and funding.

3.2.1.3.7 Medicaid Member Provider Choice and CSA Funding

- In accordance with federal Medicaid requirements, Virginia DMAS regulations also require that the individual and their parent or legally authorized representative shall have the right to freedom of choice of Medicaid-approved service providers.
- Medicaid members retain the right to freedom of provider choice for Medicaid funded services. However, this provider choice does not extend to non-Medicaid covered services (e.g., education in the residential setting). Many local governments and their CSA programs have established contractual agreements with providers of residential placements resulting in a limited set of provider options. When the member's parent wishes to receive residential treatment in a facility not under contract or where the contract is not in good standing with the locality, CSA is not obligated to fund the non-Medicaid covered components of the program. Parents opting to place their children in facilities not under contract or where the contract is not in good standing with the local CSA program may be responsible for the non-Medicaid covered components of the placement.
- Local CSA programs, parents of Medicaid-eligible children being considered for residential placement and the ~~Magellan~~BHSA Intensive Care Management team serving the locality are encouraged to work collaboratively to select placements that will best meet the needs of the child and provide maximum funding for necessary services.

3.2.1.3.8 CANS, IACCT and the OCS CANVaS Software

- ~~Magellan~~The BHSA requires that all children being authorized for Medicaid-funded residential treatment have a valid, recently completed Child and Adolescent Needs and Strengths (CANS) assessment.
- Children known to CSA:
  - ~~•~~For children currently referred to an IACCT from a FAPT/CPMT, the CANS should be completed by the CSA case manager (LDSS, CSB, CSU, or school) in accordance with state and local CSA requirements, entered into the CSA CANVaS on-line software. CSA continues to require a CANS assessment, completed by the designated CSA-related personnel, and entered into the CANVaS system.
  - With proper consent of the parent/legal guardian in accordance with local CSA consent

requirements, local CSA offices may provide copies of previous CSA-related CANS assessments to the IACCT.

- Children referred from an IACCT to a FAPT and who are determined to be eligible for CSA funding and for who an individual family service plan (IFSP) is being developed will required a "CSA completed" CANS, entered into the CANVaS system even if the IACCT has already completed a CANS. IACCT will not be utilizing the CSA specific version of the CANS and will not have access to the CANVaS system. This is to protect the integrity and security of the CSA CANVaS system as many IACCTs will be private providers not authorized to access the CANVaS system.

- For children not known to CSA and for whom a referral has been made to IACCT:
  - the IACCT will complete the CANS and enter the information into the ~~Magellan~~BHSA proprietary CANS data system in accordance with ~~Magellan~~the BHSA requirements.
  - children not currently open to CSA cannot have a CANS entered into the CANVaS system, even if completed by CSB personnel serving as the LMHP in an IACCT.

CANS Policy Revision Proposal

3.7 Child and Adolescent Needs and Strengths

"The Child and Adolescent Needs and Strengths Assessment (CANS) shall be the mandatory uniform assessment instrument for children and youth receiving services funded through the state pool. Use of the CANS shall be effective July 1, 2009."

The CANS is a valuable tool used to assess a child and family's strengths and needs. Specific items are rated on a scale to determine if strengths are present and can be built upon or identifying the needs, developing goals, service planning, and monitoring progress toward measurable outcomes.

3.7.1 6 Key CANS Principles

- "Items were selected because they are each relevant to service/treatment planning. An item exists because it might lead you down a different pathway in terms of planning actions."
- "Each item uses a 4-level rating system. Those levels are designed to translate immediately into action levels. Different action levels exist for needs and strengths. The action levels are described in greater detail throughout this training website."
- "Rating should describe the child/youth, not the child/youth in services. If an intervention is present that is masking a need but must stay in place, this should be factored into the rating consideration and would result in a rating of an "actionable" need (i.e. "2" or "3")."
- "Culture and development should be considered prior to establishing the action levels. Cultural sensitivity involves considering whether cultural factors are influencing the expression of needs and strengths. Ratings should be completed considering the child/youth's developmental and/or chronological age depending on the item. In other words, anger control is not relevant for a very young child/youth but would be for an older child/youth or child/youth regardless of developmental age. Alternatively, school achievement should be considered within the framework of expectations based on the child/youth's developmental age."
- "The ratings are generally "agnostic as to etiology." In other words, this is a descriptive tool. It is about the "what" not the "why". Only one item, Adjustment to Trauma, has any cause-effect judgments."
- "A 30-day window is used for ratings in order to make sure assessments stay "fresh" and relevant to the child/youth or youth's present circumstances. However, the action levels can be used to over-ride the 30-day rating period."

The CANS is a tool based on "communications" theory in that the ratings should be scored based on communication between all relevant agencies/disciplines and the family. It should not be considered a psychometric assessment. The CANS is a collaborative tool that when used properly should describe the family's situation and identify areas of need to inform the development of the IFSP. On an ongoing basis, it can also inform the team of progress towards reducing youth and/or family's needs and development of strengths.

3.7.2 CANS Certification

Administration of the CANS requires initial certification and annual recertification. Certification can be obtained by going to the website https://www.schoox.com/login.php, creating an account, and following instructions to complete the training. Upon completion, a copy of the certificate along with a signed User Agreement must be provided to the Local Administrator to set up a CANVaS account.

3.7.3 Administration Frequency

*Note- This policy does not replace or revise VDSS requirements for the use of CANS in certain DSS cases. DSS case managers should consult VDSS guidance to ensure compliance with their own agency policies. Where the frequencies of CANS administration intersect, one CANS may be completed, signed and submitted to meet both requirements. Case Managers must, however, use the Comprehensive version of the CANS in accordance with CSA policy.

In Frederick County, the CANS shall be completed by case managers and entered into the online CANVaS version at the established frequency below. Case managers are required to submit a CANS for all youth receiving services funded by CSA. Two versions of the CANS exist, the DSS-Enhanced CANS and the Standard CANS. Each version has separate assessments for children age birth to four and children and youth age 5+. These versions also have both Comprehensive and Reassessment types, which must be completed at a frequency established by CPMT policy.

- DSS agency case managers must use the DSS-Enhanced Version of the CANS. All other agency case managers must use the Standard Version of the CANS.
- "All assessments entered into CANVaS shall be completed and closed no later than 60 days after the assessment is initiated. Closure requires entry of all required information, and the closed assessment should be printed and signed by the assessor. Assessments not closed within 60 days shall be considered invalid and will be deleted from the system. Once deleted, the assessment cannot be retrieved." Signed CANS must be submitted via email to the CSA office.
- A CANS Comprehensive must be completed by the case manager at the following frequency:
  - Initial Referral~~, Annually,~~ and Discharge from CSA services.~~Case Closure~~
  - ~~For Foster Care Maintenance only (Basic Maintenance and Clothing Allowance) cases, a CANS is only due annually and therefore a DSS-Enhanced CANS Comprehensive is always completed.~~
- A CANS Reassessment is due at the following frequency:
  - Congregate Care settings-every 3 months
  - Private Day School placements-every 6 months
  - Treatment Foster Care Only-every 6 months
  - Community Based Services-every 3 months
  - Foster Care Maintenance only (Basic and Enhanced Maintenance/Fostering Futures Stipend, and Clothing Allowance-Annually

The following chart outlines the required frequency of CANS completion and FAPT/MDT review.

Service	FAPT/MDT Review	CANS Completion
Congregate Care (IEP Exception), ~~Adoption Assistance placements**~~	Every 3 months	Comprehensive-Initial & ~~Annually~~ Discharge Reassessment-Every 3 months ~~Discharge~~
Community Based Services, Foster Care Prevention	Every 3 months	Comprehensive-Initial & ~~Annually~~ Discharge Reassessment-Every 3 months ~~Discharge~~
Treatment Foster Care Only	Every 6 months	Comprehensive-Initial & ~~Annually~~ Discharge Reassessment-Every 6 months ~~Discharge~~
Basic & Enhanced Maintenance/Fostering Futures, ~~&~~and Clothing Only	Annually	Comprehensive-Initial & ~~Annually~~ Discharge Reassessment-Annually

Placements made through an IEP	Every 6 months, or Annually with justification to FAPT	Comprehensive-Initial & ~~Annually~~ Discharge Reassessment-Every 3 months, or 6 months for Private Day School Discharge
~~Step Down/New Placement~~Change in Level of Care ~~(except Emergency Funding)~~	Prior to change of~~in~~ placement or within 14 days if Emergency Funding	~~Upon change of placement~~As above

3.7.4 CANVaS

According to the COV § 2.2-5210, "Utilizing a secure electronic database, the CPMT and the family assessment and planning team shall provide the Office of Children's Services with client-specific information from the mandatory uniform assessment and information in accordance with subdivision D 11 of § 2.2- 2648."

CANVaS is the online ~~version~~ software ~~of the CANS~~ developed in order to meet the COV requirements to submit CANS data to OCS. Each locality is responsibility to enter individual CANS assessments into the software database for each CSA funded youth.~~used for storage and management of individual CANS assessments for every CSA funded youth. Each locality is responsibility to enter the CANS into the internet version in order to meet the COV requirements.~~

- All children and youth receiving CSA funded services shall have a CANS completed in accordance with local CPMT policy.
- Every CANS shall be entered into the CANVaS software system.
- ~~Children and youth receiving Title IV-E funded services without CSA funding shall be entered into the CANVaS system.~~
- Paper CANS score sheets may be used only if the rater is certified. All paper CANS must be entered into the CANVaS software system within 60 days.
- All CANS shall be marked as closed within 60 days of initiation. All required information must be completed for closure. CANS that are not closed within 60 days will be deleted from the system and cannot be retrieved.

ENHANCED TECHNICAL ASSISTANCE

Did you know?

THE OFFICE OF CHILDREN'S SERVICES IS NOW ABLE TO OFFER ENHANCED TECHNICAL ASSISTANCE TO LOCAL CSA PROGRAMS

Is Enhanced Technical Assistance (TA) right for your local CSA Program?

This elective program offers support to individual localities seeking to improve operations of their local CSA Program with the support of the Office of Children's Services.

What is Enhanced Technical Assistance?

With Enhanced TA, a Program Consultant works with your CPMT to make recommendations for your local program. OCS offers individualized support including:

- Observation of local CSA operations
- Programmatic recommendations provided based on consultation, data review, and team goals
- Access to training for CPMT, FAPT, Community Agencies, and CSA Staff
- Development of a Program Enhancement Plan

For more information or to request Enhanced TA, please contact the helpdesk at csa.virginia.gov

MCO CASE MANAGEMENT

FOR YOUTH IN FOSTER CARE & ADOPTION ASSISTANCE

WHAT IS AN MCO?

A Managed Care Organization (MCO) is a health insurance plan with a group of physicians and other providers who work collaboratively to deliver health care services to their members.

DMAS contracts with six (6) MCOs to provide insurance benefits to Medicaid and Family Access to Medical Insurance Security (FAMIS) members, including those in Foster Care and Adoption Assistance.

WHAT IS CASE MANAGEMENT?

Collaboration among youth and foster family (or other placement provider), local Department of Social Services (DSS) worker, and other providers to ensure appropriate, quality, and timely health care services and other resources are provided.

All youth in foster care are assigned an MCO case manager. An exception is youth placed in Residential Treatment Facilities, who receive coverage directly through Medicaid (fee-for-service). These youth can receive care coordination from Magellan of Virginia.

There is no associated cost and services are confidential.

Contact your health plan to see who your assigned Case Manager is:

Aetna Better Health
800-279-1878

Molina Complete Care
800-424-4518

UnitedHealthcare
844-752-9434

Anthem Healthkeepers Plus
800-901-0020

Optima Health
866-881-2166 (OFC)
800-546-7924 (OHCC)

Virginia Premier
800-727-7536

HOW CAN A CASE MANAGER HELP?

A case manager is a health plan employee who is a health professional with expertise in behavioral health concerns, child welfare and pediatric specialties.

IDENTIFY PROVIDERS

Such as primary care physicians, dentists, therapists or specialists. Additionally, case managers can connect you to individualized behavioral health services.

RESOLVE BARRIERS TO TREATMENT

Such as billing and pharmacy issues, changing doctors or referrals to specialists.

PROVIDE EDUCATION

About health benefits and other community resources like food, education and housing.

ADDITIONAL SERVICES

24-hr nurse advice line, toll free member helplines, disease management programs (asthma, diabetes, obesity), assistance ordering new insurance card and more.

SUPPORT FOR TRANSITION AGE YOUTH

MCO case managers assist with the successful transition from youth to adulthood, beginning by age 17:

- Help scheduling appointments
- Education about resources, benefits, and Fostering Futures
- Information about current medications & doctors
- Assisting with DSS transition planning

HELPFUL RESOURCES:

Independent Living

Foster My Future
VDSS Services - Older Youth
ProjectLIFE
UHC On My Way
Great Expectations

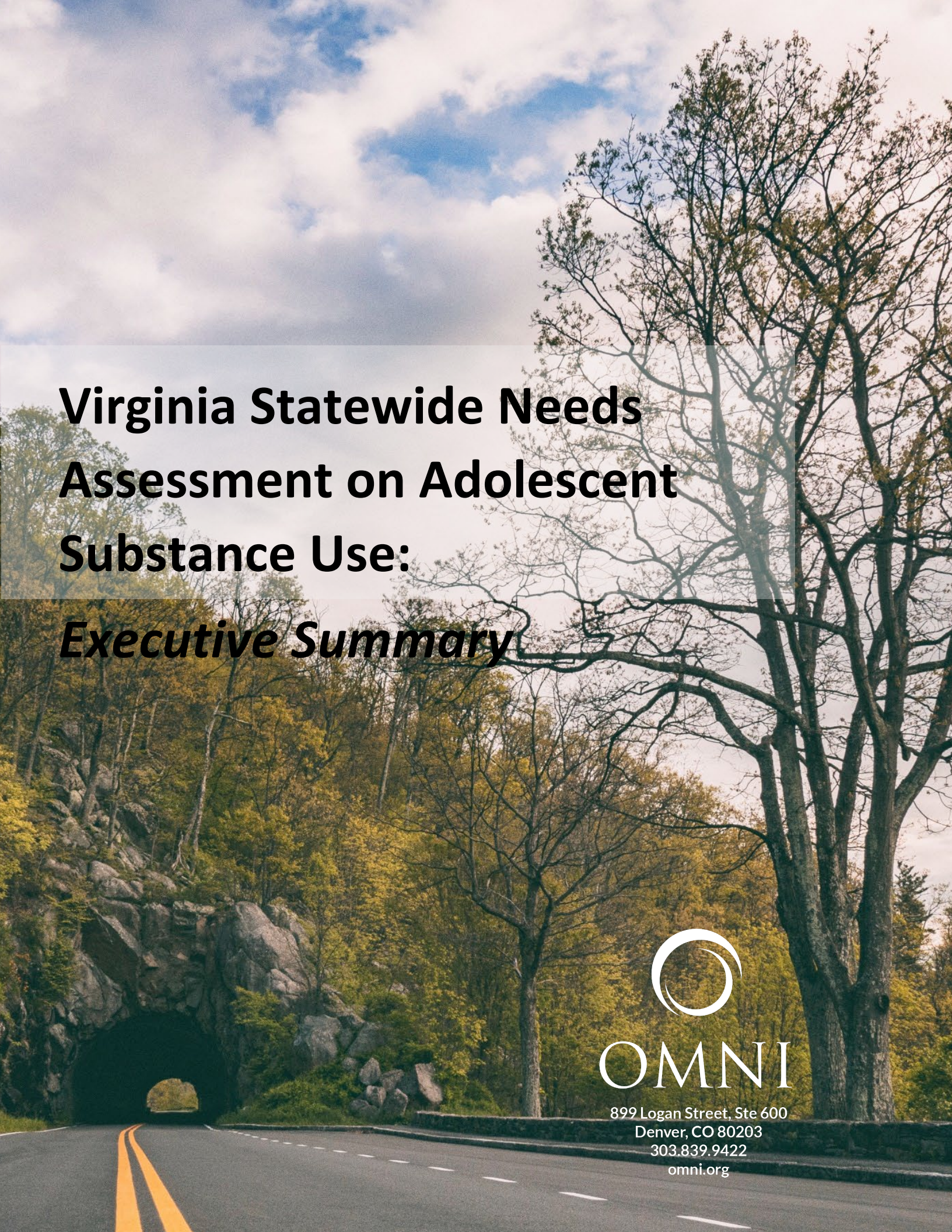
Coverage Info

Managed Care Helpline
1- 800-643-2273
(TTY: 1-800-817-6608)
Open Mon-Fri, 8:30am-6:00pm
*for additional info & to change MCOs
CoverVA
CommonHelp

Other

Local CSBs
United Way 211
Infant Toddler Connection

DMAS Foster Care Questions



Virginia Statewide Needs Assessment on Adolescent Substance Use:

Executive Summary

OMNI

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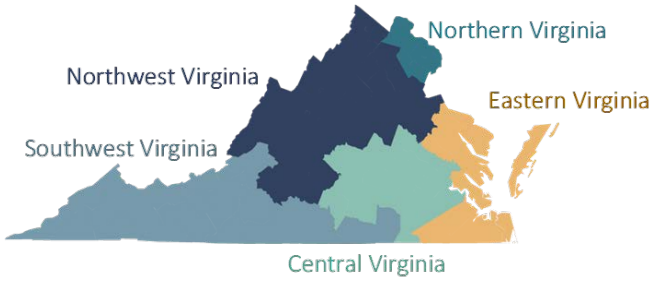
Executive Summary

Introduction and Methods

A comprehensive needs assessment of adolescent substance use services was conducted by OMNI Institute in partnership with the Office of Children and Family Services (OCFS) within the Virginia Department of Behavioral Health and Developmental Services (DBHDS). In accordance with the overarching project purpose of better understanding adolescent substance use behaviors and service needs, this report is intended to **1) describe the nature and prevalence of adolescent alcohol and drug use in Virginia; 2) highlight barriers to service access and delivery, as well as service gaps, and 3) provide recommendations for addressing this important issue in Virginia.**

To gather the relevant data and information needed to provide an in-depth understanding of adolescent substance use behaviors and service needs in Virginia, the needs assessment involved five main components of work: *Literature Review, Secondary Data Review, Provider Survey, Provider Focus Groups, and Caregiver Survey.*

Information gathered from these work areas was synthesized and organized into several main sections for reporting: *Nature and Prevalence of Need, Barriers to Service, and Gaps in Service.* Statewide findings and regional breakdowns were provided across each of these areas where data allowed based on the DBHDS regions depicted in the map on the right. The report concludes with a *Key Reflections and Recommendations* section that takes the key findings from the needs assessment and outlines implications and potential areas of system improvement for the state to consider moving forward. Highlights from each of these sections are presented below.



Nature and Prevalence of Need

Overall, adolescent substance use trends in Virginia strongly parallel those found at the national level when reviewing data from the National Survey of Drug Use and Health (NSDUH, 2020), with the exception of all indicators of problematic alcohol use, which were higher among Virginia youth. Further, the secondary data review also revealed that the most prevalent substances of concern among adolescents in Virginia are **marijuana, alcohol, and electronic vaping** (Virginia Youth Survey- High School, 2019). These were also the substances that providers taking the needs assessment survey reported seeing being used the most by their adolescent clients.

Approximately **20% of respondents reported electronic vaping** in the previous month

17% of youth report having used marijuana at least one day in the previous month

Nearly 13% reported binge drinking in the last 30 days

Although providers in the focus groups discussed the increase in the use of harder drugs, they still saw marijuana and alcohol as the most common substances used. Providers attribute this to the social acceptability and availability of these substances. They shared that although marijuana and alcohol are seen as less deadly or serious than methamphetamine or opioids, providers are still seeing extremely heavy use of these substances, which they say still leads to harmful physical and mental outcomes.

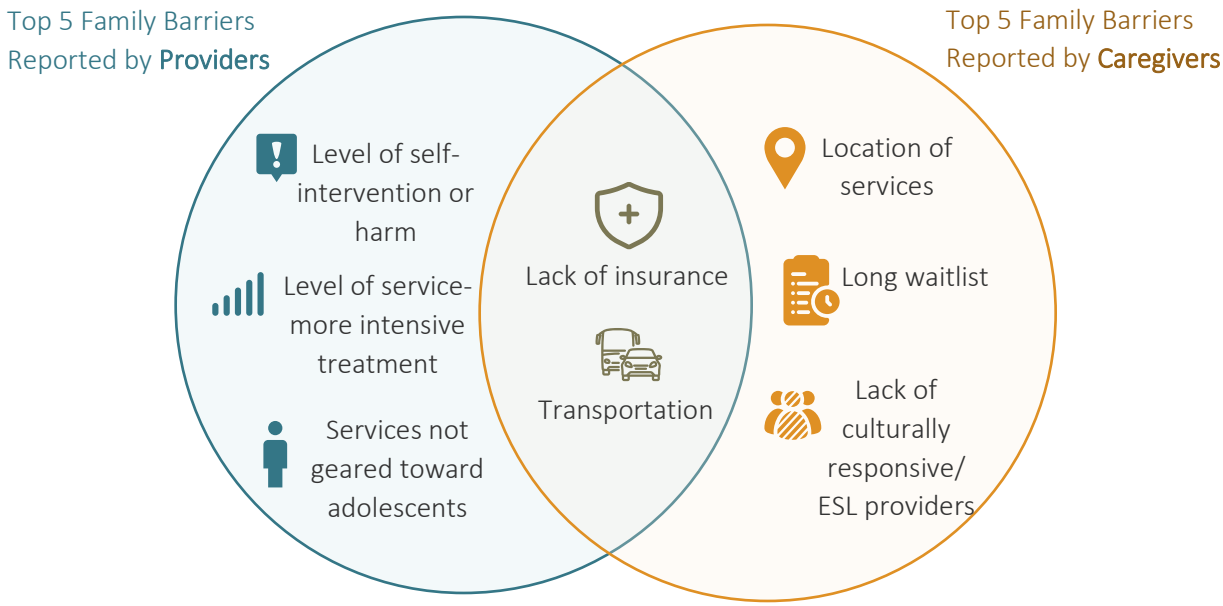
Barriers to Accessing and Providing Services

According to the literature review and findings derived from the primary data collection efforts of this needs assessment, adolescents and their caregivers face a number of barriers to accessing substance use that can be categorized into two overarching categories: *systemic and personal/family barriers.* The most pervasive systemic and personal/family barriers are presented below.

Most Common Systemic Barriers Reported

- Logistical barriers
- Limited capacity
- Lack of adolescent-specific and culturally relevant services
- Insurance requirements and limitations
- Difficulties accessing appropriate treatment due to services and financial constraints

Top 5 Personal/Family Barriers Reported

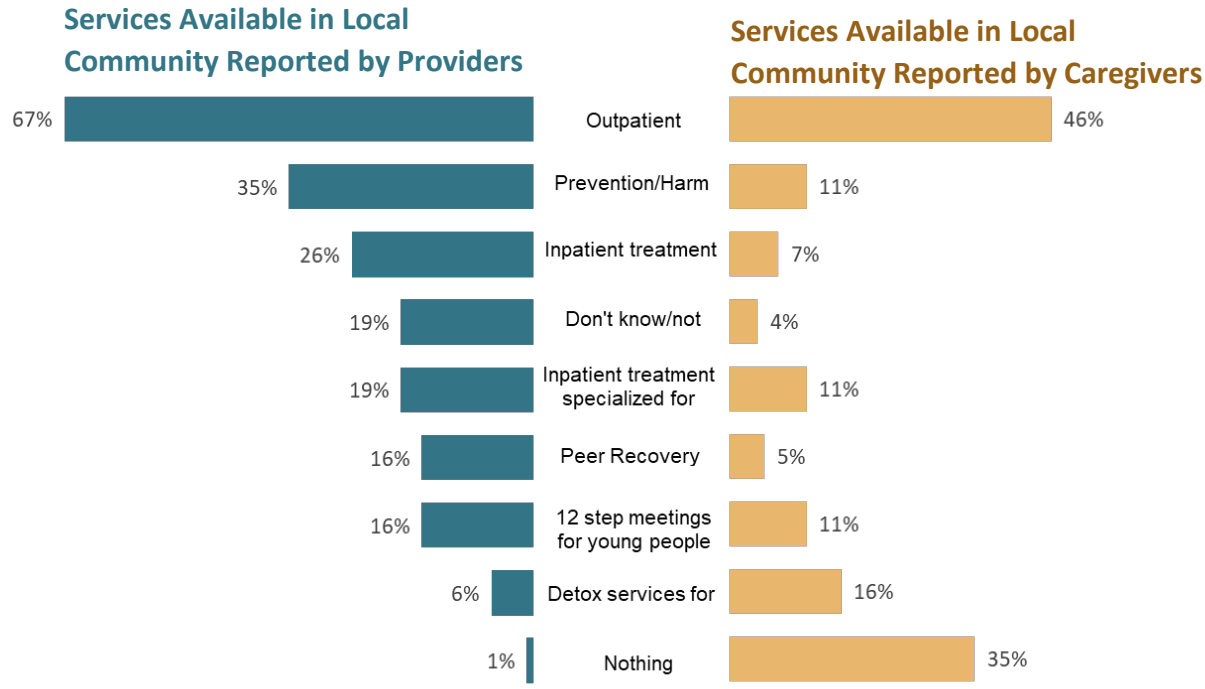


Interestingly, the perceived family barriers from the provider perspective were somewhat different from those actually raised by caregivers in the needs assessment survey, as depicted in the figure above. This highlights the importance of truly incorporating the family voice when considering approaches and strategies to best mitigate barriers to accessing adolescent substance use services. Relatedly, providers also encounter several barriers when *providing* services, such as finding the appropriate level of care for their clients and coordinating care across different systems and providers.

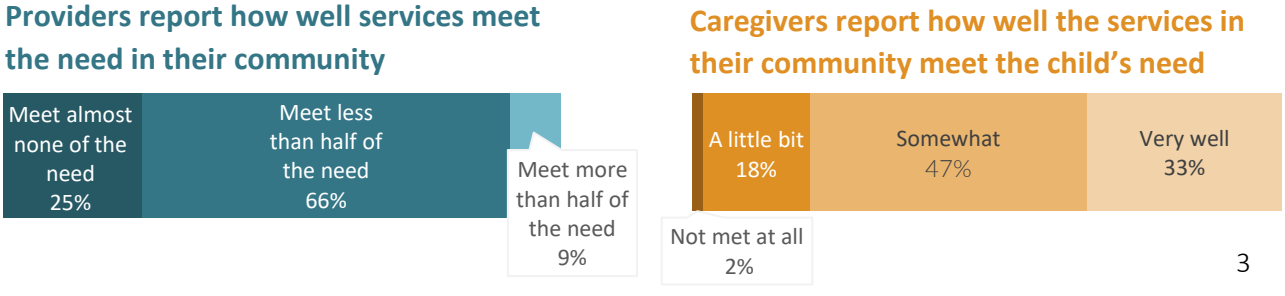
Gaps in Service

Service providers and caregivers were asked what adolescent substance use services were available in their community and the degree to which those services were meeting the need. As illustrated below, the most commonly recognized adolescent substance use service across the Commonwealth was outpatient services, followed be prevention/harm reduction efforts. Notably, over 1/3 of caregivers indicated that they were unaware of any services being available for adolescent substance use in their community.

Overall, findings also suggest that caregivers have less overall knowledge and awareness of available services in their community indicating a need for greater parental education and support.



When asked the degree to which services are meeting the needs in the community, most providers indicated that that the services were meeting less than half of the community need. Similarly, only 1/3 of caregivers indicated that the services in their community are meeting the needs of their child "very well."



Key Reflections & Recommendations

This needs assessment generated several key findings related to adolescent substance use in Virginia, as highlighted below:

- Statewide trends in self-reported alcohol and drug use and related arrests mostly parallel national statistics.
- The primary substances most frequently being used among adolescents across the Commonwealth are marijuana, alcohol, and electronic vaping, with some regions also raising concerns around prescription drug use.
- According to caregivers and providers, families encounter numerous systemic and personal barriers when attempting to access adolescent substance use services, including transportation and location of services, as well as difficulty navigating insurance challenges and finding culturally responsive services.
- Providers raised concerns around caregivers and adolescents not fully acknowledging the severity of substance use issues, and caregivers shared resistance to seeking services due to perceived stigma of doing so.
- Providers shared that the disjointed and inadequate system of care for adolescent substance use in Virginia makes it difficult for them to find the appropriate level of care for their clients and facilitate that service connection.
- When asked about service provision, providers and caregivers shared that there are limited options available targeting adolescent substance use, and what is available is not fully meeting the needs in their communities.
- Providers and caregivers saw a need for improvements across the continuum of care to better address adolescent substance use in Virginia, from enhancing adolescent-specific harm reduction and prevention efforts to include more robust parental education programming, to farther along the continuum with the implementation of peer recovery models and expanding adolescent inpatient treatment options.

Based on the findings presented above, a key recommendation that stemmed from this project is for the state to move toward establishing an adolescent-specific continuum of care that spans prevention, early intervention, treatment, and recovery. Providers in Virginia echo the best practice recommendations (SAMHSA, 2016) that suggest services along that continuum need to be adolescent-focused and delivered by a well-trained and supported workforce. According to providers, the continuum of care should also include supportive services for caregivers and families of adolescents who use substances. To develop and implement an integrated continuum of care that can both prevent and address substance use among adolescents, it is important to reflect on existing research and the broader evidence base on this topic. Additional research on best practices pertinent to an adolescent substance use continuum of care is available in Appendix F.

In general, providers that completed the needs assessment survey indicated that the existing system of substance use care in Virginia is not meeting the needs of adolescents and their families. From the provider perspective, a stronger, more cohesive and integrated system of care is needed to better meet the needs of their adolescent clients. While many providers shared that they felt confident identifying the substance use needs of their clients and providing basic supportive and outpatient services, they felt less

equipped to support adolescents and their families with accessing different levels of care outside of their service provision. This finding suggests that a **case management and wrap-around model** might play a key role in bolstering the existing system and helping adolescents and their families get connected to needed services early on **to potentially avoid formal child welfare or juvenile justice system involvement.**

One interesting finding that emerged through this needs assessment is that **providers and caregivers differed in their perspectives around several issues pertinent to this topic,** including specific substances of concern, barriers to accessing services, and available services in their respective communities. This indicates that these two groups do not have a shared understanding of this important issue, and as key stakeholders supporting adolescents in Virginia this raises an important gap to be addressed. Most notably, **caregivers reported far less knowledge of available services in their communities** when compared to providers. Caregivers also shared that they wish they had more information about where to turn for support and resources around their child's substance use needs and how to better communicate effectively with their children about their concerns. These results suggest that **additional efforts are needed across the Commonwealth to increase general awareness around service availability and provide caregivers with easier access to resources and supportive communication tools.**

Highlighting the disconnect between the provider and caregiver perspectives illustrates the importance of **prioritizing the family voice** in the development and enhancement of the adolescent substance use system of care. Too often, system stakeholders lead the decision-making process without caregiver input resulting in systems that are creating rather than eliminating barriers for caregivers. A key recommendation for local and state leaders would be to closely examine the barriers that were raised by caregivers here and work with a local or state caregiver advisory board to further unpack those barriers and identify potential solutions to ensure the system is truly being designed in an inclusive and informed way. For instance, communities should prioritize **ensuring equitable access to services** for those with limited financial resources or insurance coverage (SAMHSA, 2016). Improving access to insurance coverage or eliminating financial barriers to accessing services could be a key aspect of improving service provision and increasing utilization.

Because best practices recommend that services for adolescents should be tailored to meet their needs, including the individual experience of the adolescent as well as their cultural background (SAMHSA, 2016), and because our findings suggest that each region of the state has unique strengths and challenges, **services should continue to be developed and implemented at the regional and community levels**. A more localized approach allows the continuum of care to consider the context of a region or community in the development and implementation of substance use services. For example, both Southwest and Northern Virginia caregivers reported that the location of service delivery was a barrier for their family. However, the solutions that might be prudent in Northern Virginia, such as providing passes to use public transportation, would not necessarily work well in Southwest Virginia where communities are more spread out and public transport is less available. Therefore, these initial findings help illuminate additional areas for research in and collaboration with local agencies, CSBs, and providers to improve services in ways that target the gaps barriers and build on the strengths of local communities.

Conclusion

Findings from this needs assessment indicate that there are committed providers and leaders, and a robust substance use response infrastructure in Virginia. However, there remain considerable gaps in service along the continuum of care when it comes to service provision for adolescents. Many of the services currently in place are geared toward adults and little support is available for caregivers and families of adolescents with substance use concerns. Moving forward, local and state leaders should consider centering the family voice and leverage the existing infrastructure to integrate or adapt evidence-based adolescent-specific practices across the continuum of care to enhance the system of care for adolescents with substance use needs and their families in Virginia. In addition, incorporating the local context and partnering with key community stakeholders will be critically important to ensuring that local systems of care are tailored to meet the unique needs of each community across the Commonwealth. As an immediate next step, building from this needs assessment to engage in an in-depth strategic planning and implementation planning process at the state and regional levels will set the stage for data-driven, thoughtful, and responsive implementation of adolescent substance use system of care improvements throughout Virginia.