FAIRFAX-FALLS CHURCH CHILDREN'S SERVICES for AT-RISK CHILDREN, YOUTH & FAMILIES

July 29, 2022
Community Policy and Management Team (CPMT)

Agenda

1:00 p.m. -- Convene meeting ~

1. **MINUTES:** Approve minutes of May 20, 2022 meeting

2. **ITEMS:**

- **Administrative Items**
  Item A – 1: Approve Mental Health Initiative Funding Plan and Protocol
  Item A – 2: Policy for Use of Virtual Platform Participation in CPMT Meetings
  Item A – 3: Policy for Intensive Care Coordination Expedited Access
  Item A – 4: Policy for Expansion of Case Support Services
  Item A – 5: Policy for Utilization Reviews and Billing Procedures
  Item A – 6: Policy and Practice Standards for Preferred Name and Pronoun
  Item A – 7: Policy for CSA Standard Services: Emergency Supervision and Support for Youth in Foster Care

- **CSA Contract Items**
  Item C – 1: Monthly Out-of-State Placement Approvals

- **CSA Information Items**
  Item I – 1: Budget Report
  Item I – 2: Human Services Legislative Issue Paper
  Item I – 3: Update on Private Day Rate Setting
  Item I – 4: Procedures for Access to Foster Care Maintenance/KinGap

- **NOVACO – Private Provider Items**
- **CPMT Parent Representative Items**
- **Cities of Fairfax and Falls Church Items**
- **Public Comment**

3:00 p.m. – Adjourn

FAIRFAX-FALLS CHURCH CHILDREN'S SERVICES for AT-RISK CHILDREN, YOUTH & FAMILIES

May 20, 2022
Community Policy and Management Team (CPMT)
Virtual Meeting due to COVID-19 Emergency Procedures

Meeting Minutes

Attendees: Lesley Abashian (office -*acting Vice Chair*), Gloria Addo-Ayensu (office), Jacqueline Benson (home), Cristy Gallagher (office), Annie Henderson (office), Joe Klemmer (home), Dana Lewis (office) Richard Leichtweis (home – *acting Chair*) Dawn Schaefer (office), Matt Thompson (office), Lloyd Tucker (office)

Attended but not heard during roll call: Lyn Thomlinson – *sitting in for Daryl Washington* (office), Michelle Boyd

Absent: Lloyd Tucker, Staci Alexander, Michael Becketts, Deb Evans, Deborah Scott, Chris Leonard, Rebecca Sharp

HMF Attendees: Peter Steinberg, Jim Gillespie, Tracy Davis, Hilda Calvo Perez, Philethea Duckett

CSA Management Team Attendees: Kelly Conn-Reda, Xu Han, Barbara Martinez, Jessica Jackson, Tim Elcesser, Kamonya Omatete, Muhammad "Usman" Saeed, Andrew Janos, Terry Byers, Mary Jo Davis, Jesse Ellis, Julie Bowman

Stakeholders and CSA Program Staff Present: Janet Bessmer, Kristina Kallini, Shana Martins, Kendra Rascoe, Tiffany Robinson, Jeanne Veraska, Chris Metzbower, Jesse Ellis

FOIA Related Motions:

I move that each member's voice may be adequately heard by each other member of this CPMT.
Motion made by Rick Leichtweis; second by Matt Thompson; all members agree, motion carries.

Second, having established that each member's voice may be heard by every other member, we must next establish the nature of the emergency that compels these emergency procedures, the fact that we are meeting electronically, what type of electronic communication is being used, and how we have arranged for public access to this meeting.

State of Emergency caused by the COVID-19 pandemic makes it unsafe for this CPMT to physically assemble and unsafe for the public to physically attend any such meeting, and that as such, FOIA's usual procedures, which require the physical assembly of this CPMT and the physical presence of the public, cannot be implemented safely or practically. I further move that this CPMT may conduct this meeting electronically through a dedicated auto conferencing line, and that the public may access this meeting by calling: 571-429-5982; participant access code: 341 991 249#. It is so moved.
Motion made by Rick Leichtweis; seconded by Jackie Benson; all members agree, motion carries.

Finally, it is next required that all the matters addressed on today's are statutorily required or necessary to continue operations and the discharge of the CPMT's lawful purposes, duties, and responsibilities.
Motion made by Rick Leichtweis; seconded by Jackie Benson; all members agree, motion carries.

Approved:

1. **MINUTES:** Approve minutes of April 29, 2022. *Motion made by Matt Thompson; seconded by Dawn Schaefer; all members agree, motion carries.*

2. **ITEMS:**

- **Administrative Items:**

  Item A – 1: FY23 CPMT Meeting Schedule – presented by Janet Bessmer. Request for approval for the proposed FY23 CPMT meeting schedule. Joe Klemmer asked when CPMT will begin in person. Janet Bessmer responded that we may reconvene in person either in June or July (but we are still unsure of the exact time) unless the county adopts the practice of keeping the meetings virtual. *Motion made by Cristy Gallagher; seconded by Matt Thompson; all members agree, motion carries.*

  Item A – 2: OCS Annual Risk Assessment Survey for Localities– Presented by Janet Bessmer. The state sends a required survey each year to ask about a variety of issues regarding the functioning of CSA program. The survey was completed using the information from the CSA program (full survey responses can be found the meeting materials packet). Request that CPMT approve submission of this survey to the state. *Motion made by Joe Klemmer; seconded by Matt Thompson; all members agree, motion carries.*

- **CSA CONTRACT ITEMS:**
  Item C – 1: Monthly Out-of-State Placement Approvals – CSA Management Team approved a child-specific contract with Sandy Pines Residential Treatment facility in FL.

- **CSA INFORMATION ITEMS:**
  Item I – 1: Budget Report – Presented by Usman Saeed. Refer to packet for information regarding the budget report.
  Item I – 2: Mental Health Initiative Local Funding for FY23 – Presented by Jessica Jackson. Refer to packet for more information.
  Item I – 3: Mental Health Initiative State Revisions – Presented by Jessica Jackson. Refer to packet for more information.

  - **NOVACO – Private Provider Items –** Quarterly meeting with CSA managers. Regional discussion on opioid crisis and provider capacity issues. Also discussed CSA symposium which will be held June 8 8am-1pm at NOVA Community College. This is a free event for CPMT members and there will be a CPMT round table discussion (more details to come).
  - **CPMT Parent Representative Items –** none
  - **Cities of Fairfax and Falls Church Items –** none
  - **Public Comment –** none
  - **Staff Comment –** Jim Gillespie announced that he will be retiring in August.

Next Meeting: June 24, 2022, 1:00 – 3:00pm (location TBD)

Adjourn 1:40pm: *Motion to adjourn made by Lesley Abashian; seconded by Joe Klemmer; all members agree, motion carries.*

Approved:

MEMO TO THE CPMT
July 29, 2022

Administrative Item A – 1: Approve Mental Health Initiative Funding Plan and Protocol

ISSUE:
It is requested that the CPMT approve a funding plan for DBHDS Mental Health Initiative funds allocated to the Community Services Board. The plan and protocol include the annual allocation of $515,529 and approximately $1 million in unspent prior year state Mental Health Initiative funds. On June the CSA Management Team reviewed and endorsed this request.

RECOMMENDATION:
that the CPMT approve a funding plan for DBHDS Mental Health Initiative funds allocated to the Community Services Board. The plan and protocol include the annual allocation of $515,529 and approximately $1 million in unspent prior year state Mental Health Initiative funds.

BACKGROUND:
The Mental Health Children and Adolescent Initiative (MHI) is a Virginia Department of Behavioral and Developmental Health (DBHDS) funding allocation to CSBs dedicated to serving children and adolescents with serious emotional disturbance and other disorders who are not mandated to receive services under the Children's Services Act (CSA). The annual MHI allocation to the Fairfax-Falls Church CSB is $515,529. For the past several years the state MHI allocation has been under-spent, resulting in a current unspent balance of approximately $1 million. DBHS requires that be spent for the intended purpose.

The current annual MHI allocation is used to support four Youth and Family Behavioral Health Specialist II positions and to purchase intensive behavioral health treatment for children and youth with more complex needs than can be met through outpatient services. In addition, in order to spend down the accumulated balance, in January 2020 CPMT endorsed and DBHDS approved also funding three Senior Clinician positions to begin spending down the accumulated balance. After the onset of COVID that number was reduced to two, with DBHDS concurrence. In January 2021 the CPMT endorsed and DBHDS approved spending $300,000 annually in purchased services for MHI-eligible youth, to further reduce the accumulated balance. The unspent balance was accumulated through periodic vacancies in the MHI-funded positions, which had the added effect of reducing the case management capacity to assist families in accessing MHI-funded intensive behavioral health treatment.

DBHDS MHI Administrative Requirements:

- MHI funds must be used exclusively to serve currently unserved children and adolescents or provide additional services to underserved children and adolescents with serious emotional disturbances, at risk for serious emotional disturbance, and/or with co-occurring disorders with priority placed on those children who, absent services, are at-risk for removal from the home due to placement by a local department of social services, admission to a congregate care facility or acute care psychiatric hospital or crisis

stabilization facility, commitment to the Department of Juvenile Justice, or parental custody relinquishment.

- Services must be based on the individual needs of the child or adolescent and must be included in an individualized services plan. Services must be child-centered, family focused, and community-based. The participation of families is integral in the planning of these services.
- MHI funds must be used to purchase services which will be used to keep the child or adolescent in the least restrictive environment and living in the community.
- These funds shall be used exclusively for children and adolescents, not mandated for services under the Children's Services Act.
- The CSB shall develop a Mental Health Initiative funding plan in collaboration with the local Family and Assessment Planning Team and/or Community Policy and Management Team. The funding plan shall be approved by the Community Policy and Management Teams of the locality. The CSB should seek input and guidance in the formulation of the protocol from other FAPT and CPMT member agencies.
- MHI funds may not be used for residential care services, partial or full hospitalizations, or for CSA sum sufficient populations. MHI funding may not be used to purchase vehicles, furniture, computers, or to provide training.

The new language is much clearer about the role of FAPTs and CPMTs in planning for use of MHI funds. Currently DBHDS requires that CSBs work collaboratively with local Community Policy Management Teams (CPMTs) to establish a MHI Fund Protocol for how the CSB will expend the MHI funds for the target population. The new budget amendment establishes a requirement that the CPMT approve a MHI funding plan.

The new priority for serving "children who, absent services, are at-risk for removal from the home due to placement by a local department of social services" sews confusion about whether to serve them through CSA or MHI. Those children would appear to be mandated under CSA, which would make them ineligible for MHI funding. CSB MHI procedures will specify that MHI funds not be used for CSA sum sufficient populations.

PROPOSED PROTOCOL:

It is proposed that the annual MHI allocation and unspent balance be spent to:

1. Continue funding four Youth and Family Behavioral Health Specialist II positions to provide case management for children and youth requiring more intensive services than outpatient.

2. Continue funding two CSB Youth and Family Senior Clinician positions. These clinicians are trained in and provide evidence-based treatments for children and youth with SED.

3. Budget $300,000 annually to purchase services for MHI-eligible youth. Types of services that these funds may be used for include, but are not limited to: crisis intervention and stabilization, outpatient, intensive in-home, intensive care coordination, case management,

Family Support Partners, evidence-based practices, therapeutic day treatment, alternative day support (including specialized after school and summer camp, behavior aide, or other wrap-around services), and, supervised family support services.

These proposed uses will meet all Appropriations Act and DBHDS State Performance Contract requirements.

Target Population:
MHI funding is targeted to unserved or under-served children and adolescents with serious emotional disturbances, at risk for serious emotional disturbance, and/or with co-occurring disorders with priority placed on those children who, absent services, are at-risk for removal from the home due to placement by a local department of social services, admission to a congregate care facility or acute care psychiatric hospital or crisis stabilization facility, commitment to the Department of Juvenile Justice, or parental custody relinquishment.

Access to Services:
Children and youth identified at inter-agency family assessment and planning team meetings, family resource meetings, family partnership meetings or ICC youth and family team meetings as meeting MHI eligibility criteria will be considered for MHI-funded treatment services. In addition, children and youth entering services through the CSB Entry and Referral process will be assessed for MHI eligibility.

Individualized Service Planning:
All youth served will have an individualized plan of care compliant with the requirements in the CSA Code, developed through a multi-disciplinary team process.

Services to be Provided:
Types of services that these funds may be used for include, but are not limited to: crisis intervention and stabilization, outpatient, intensive in-home, intensive care coordination, case management, Family Support Partners, evidence-based practices, therapeutic day treatment, alternative day support (including specialized after school and summer camp, behavior aide, or other wrap-around services), and, supervised family support services.

Review and Reporting:
A report of MHI services and expenditures will be presented to the CPMT on an annual basis.

ATTACHMENT: None

INTERNAL CONTROL IMPACT: None

FISCAL IMPACT:
The unspent MHI balance is sufficient to fund two Senior Clinician positions and $300,000 annually in purchase of services through at least FY 2023.

STAFF:
Jim Gillespie, CSB Youth and Family Services Director

MEMO TO THE CPMT

July 29, 2022

Administrative Item A - 2: Policy for Use of Virtual Platform for CPMT Meetings

ISSUE: That Fairfax County permits Boards, Authorities, and Commissions to approve revised policy allowing remote participation in public meetings by members when certain conditions are met. Furthermore, Fairfax County has approved a new policy which permits two, non-consecutive, all-virtual meetings per calendar year.

BACKGROUND: In preparation for on-going meetings of the CPMT after emergency regulations have been suspended, the CPMT may consider adopting a new, *All-virtual Participation Policy*, permitting the Board to hold 25% of meetings each calendar year virtually. Fairfax County has *Remote Participation Policy* (permitting remote participation for members when certain criteria is met), which was adopted by the CPMT July 30, 2021. The attached draft policy has been prepared by the county attorney's office using standard language.

These policies would be adopted pursuant to the authorization of Va. Code § 2.2-3708.3 is to be strictly construed in conformance with the Virginia Freedom of Information Act (VFOIA), Va. Code §§ 2.2-3700—3715. This policy shall not govern an electronic meeting conducted to address a state of emergency declared by the Governor or the Fairfax County Board of Supervisors. Any meeting conducted by electronic communication means under such circumstances shall be governed by the provisions of Va. Code § 2.2-3708.2.

RECOMMENDATION: That the CPMT approves the All-Virtual Participation policy.

ATTACHMENT: Attachment 1 – The CPMT Policy for All-Virtual Public Meetings

INTERNAL CONTROL IMPACT: None

FISCAL IMPACT: None

STAFF:
Janet Bessmer, CSA

THE COMMUNITY POLICY & MANAGEMENT TEAM (CPMT) POLICY FOR ALL-VIRTUAL PUBLIC MEETINGS

1. AUTHORITY AND SCOPE

a. This policy is adopted pursuant to the authorization of Va. Code § 2.2-3708.3 and is to be strictly construed in conformance with the Virginia Freedom of Information Act (VFOIA), Va. Code §§ 2.2-3700—3715.

b. This policy shall not govern an electronic meeting conducted to address a state of emergency declared by the Governor or the Fairfax County Board of Supervisors. Any meeting conducted by electronic communication means under such circumstances shall be governed by the provisions of Va. Code § 2.2-3708.2.

2. DEFINITIONS

a. "**BAC**" means the Fairfax County Community Policy & Management Team or any committee, subcommittee, or other entity of the CPMT.

b. "**Member**" means any member of the CPMT.

c. "**All-virtual public meeting**", means a public meeting conducted by the CPMT using electronic communication means during which all members of the public body who participate do so remotely rather than being assembled in one physical location, and to which public access is provided through electronic communication means, as defined by Va. Code § 2.2-3701.

d. "**Meeting**" means a meeting as defined by Va. Code § 2.2-3701.

e. "**Notify**" or "**notifies**," for purposes of this policy, means written notice, including, but not limited to, email or letter, but does not include text messages or messages exchanged on social media.

3. WHEN AN ALL-VIRTUAL PUBLIC MEETING MAY BE AUTHORIZED

An all-virtual public meeting may be held under the following circumstances:

a. It is impracticable or unsafe to assemble a quorum of the CPMT in a single location, but a state of emergency has not been declared by the Governor or Fairfax County Board of Supervisors; or

b. Other circumstances warrant the holding of an all-virtual public meeting, including, but not limited to, the convenience of an all-virtual meeting; and

c. The CPMT has not had more than two all-virtual public meetings, or more than 25 percent of its meetings rounded up to the next whole number, whichever is greater, during the calendar year; and

d. The CPMT's last meeting was not an all-virtual public meeting.

4. PROCESS TO AUTHORIZE AN ALL-VIRTUAL PUBLIC MEETING

a. The CPMT may schedule its all-virtual public meetings at the same time and using the same procedures used by the CPMT to set its meetings calendar for the calendar year; or

b. If the CPMT wishes to have an all-virtual public meeting on a date not scheduled in advance on its meetings calendar, and an all-virtual public meeting is authorized under Section 3 above, the CPMT Chair may schedule an all-virtual public meeting provided that any such meeting comports with VFOIA notice requirements.

5. ALL-VIRTUAL PUBLIC MEETING REQUIREMENTS

The following applies to any all-virtual public meeting of the CPMT that is scheduled in conformance with this Policy:

a. The meeting notice indicates that the public meeting will be all-virtual and the CPMT will not change the method by which the CPMT chooses to meet without providing a new meeting notice that comports with VFOIA;

b. Public access is provided by electronic communication means that allows the public to hear all participating members of the CPMT;

c. Audio-visual technology, if available, is used to allow the public to see the members of the CPMT;

d. A phone number, email address, or other live contact information is provided to the public to alert the CPMT if electronic transmission of the meeting fails for the public, and if such transmission fails, the CPMT takes a recess until public access is restored;

e. A copy of the proposed agenda and all agenda packets (unless exempt) are made available to the public electronically at the same time such materials are provided to the CPMT;

f. The public is afforded the opportunity to comment through electronic means, including written comments, at meetings where public comment is customarily received; and

g. There are no more than two members of the CPMT together in one physical location.

6. RECORDING IN MINUTES:

Minutes are taken as required by VFOIA and must include the fact that the meeting was held by electronic communication means and the type of electronic communication means used.

7. CLOSED SESSION

If the CPMT goes into closed session, transmission of the meeting will be suspended until the public body resumes to certify the closed meeting in open session.

8. STRICT AND UNIFORM APPLICATION OF THIS POLICY

This Policy shall be applied strictly and uniformly, without exception, to the entire membership, and without regard to the matters that will be considered or voted on at the meeting.

MEMO TO THE CPMT

July 29, 2022

Information Administrative Item A - 3: Policy for Intensive Care Coordination Expedited Access

ISSUE: That Intensive Care Coordination (ICC) facilitation can be accessed quickly on behalf of children and families who meet the criteria for this service to support children with significant behavioral health needs in the community.

BACKGROUND:

Currently, a family can wait two to three months for their first ICC Youth and Family Team meeting. After a family alerts their Case Manager of their need for intensive services, the case manager must first request a team-based planning meeting, and then submit the request for ICC to the CSA office. The first Youth and Family Team meeting occurs 30 days after ICC inception. At that meeting the team and family can finally begin the planning process. But the family in crisis has had to wait 60 days or more for the ICC service to begin. With the expedited FAPT services planning process, ICC could begin planning with the family in almost half the time.

There is some redundancy in having a family attend a team-based planning meeting to request a team-based planning service. ICC is designed to be service that can quickly respond to changes/crises – flexible meetings, ability to quickly start/adjust CSA-funded services, ability to quickly change crisis plans. A more streamlined, faster referral process would mirror the purpose of ICC and allow families access to intensive services before crises intensify.

INTERNAL CONTROL IMPACT: None

FISCAL IMPACT: None

ATTACHMENT: Local Policy Manual Revisions

STAFF:
Jessica Jackson, CSB

Attachment: Local Policy Manual

15.6 Service Authorization Procedures (pg. 75)

Funding Eligibility

Youth will be screened for CSA ~~mandated~~ funding eligibility for ICC services based on the existing criteria. Non-mandated referrals may be approved for ICC services in the non-mandated or MHI state categories. Funding of ICC from these capped, non-mandated sources must be sufficient to cover the costs of care coordination and community-based interventions. Budget planning for those funds should anticipate the need to fund ICC referrals.

Initial Authorization

1. ICC services may be authorized through the standard request process following a team-based planning meeting. Initial approval for ICC shall not exceed six months and may be for a shorter duration.

2. The array of community-based services to accompany facilitation can be approved only if a parental contribution assessment has been completed. ICC facilitation and family support partners may be approved without the accompanying services array, pending completion of the parental contribution assessment and for families who intend to privately purchase services.

3. *The expedited service planning process may be used to request ICC- facilitation and family support partners for up to 60 days. Additional authorization of services follows standard procedures and requirements.*

Re-authorization of ICC Services

1. Upon consensus of the Youth and Family Team (YFT) members, the Lead case manager shall be responsible for requesting re-authorizations.
2. *For ICC cases that were initiated via the expediated service planning process, re-authorization of care coordination and inclusion of community-based funding should be requested prior to the termination of the 60 days of care coordination authorization. Services may then occur for two additional six-month periods followed by a one-month period for a maximum of 15 months*.
3. Re-authorization of ICC services requested the standard team-based planning process may occur after the first six months of service for an additional six months followed by three months for a maximum of 15 months.
4. *If an episode of ICC services has a break of less than six months, the 15 months of care includes service before and after the break. If the break is greater than six months, any new ICC approvals will be considered a new episode of care for up to the full 15 months.*
5. In rare circumstances, the child and family team may determine that more time is needed for ICC services. In these instances, the lead case manager is responsible for submitting an ICC extension request to CSA Management Team.

6. To request re-authorizations, case managers shall submit along with the required documents, the following:
    - Current Plan of Care (POC)
    - Crisis Safety Plan
    - Functional Behavioral Assessment
    - Current Provider Reports (if applicable)

15.9 ~~Finance and Payment Documentation Procedures~~ *Funding Allocations and Fiscal Procedures*

1. The beginning and final month of ICC facilitation may be ~~is~~ paid ~~as~~ on a pro-rated ~~amount~~ *basis* for partial months of service.
2. Total expenditures for services during ICC shall not exceed $60,000. $25,000 may be authorized for each six-month period of service with $10,000 allocated for the final month.
3. Over the 15-month intervention, the types and amounts of services that may be selected by the ICC Youth and Family Team and encumbered by the CSA case manager include:
    - Community-based Interventions (e.g., home-based services, ABA, mentoring, interpretation, psychiatric services, transportation, recreation) up to $38,000
    - Crisis intervention/stabilization in-home or at a short-term *out of home* program with a planned length of stay of 90 days or less–up to $20,000
    - Respite (In-home and out of home) for caregivers–up to $18,000
    - Flexible funds–up to $5,000
4. If the youth require an out-of-home service during the ICC intervention, the expenditure is deducted from the overall ICC budget. The intensive care coordinator is responsible for monitoring expenditures to ensure that they remain within authorized limits.
5. CSA Management Team approval is required to authorize expenditures more than the limits for each subcategory above and for extensions of ICC services beyond the 15 months. The Lead Case Manager shall present a written request for signed approval by the CSA Management Team.

~~4. Community-based and short term out-of-home (90 days or less) interventions may be accessed through the approved encumbrance process. Total expenditures for such services shall not exceed $25,000 in the first six months of the ICC intervention.~~

~~5. If ICC is approved for continuation beyond the first six months, expenditures for community-based and short-term out-of-home interventions shall not exceed $25,000 for the subsequent six-month period and $10,000 for the final three months. The total ICC intervention shall not exceed 15 months.~~

7. If the Plan of Care includes *Medicaid-defined interventions such as* Intensive In-Home, Therapeutic Day Treatment/Partial Hospitalization, and/or Mental Health Skill Building, the team will ensure that an independent clinical assessment by a licensed clinician documents that the DMAS criteria are met. The

ICC record must contain documentation that the Medicaid criteria were met even for youth who are not enrolled in Medicaid.

8. For youth with active Medicaid, all Medicaid providers must be explored prior to accessing CSA funds. If a non-Medicaid provider is utilized, documentation must be provided *in the ICC record* demonstrating that Medicaid providers are unavailable or inappropriate.

9. Although ICC is designed as a family-based intervention, when CSA is the funding source all CSA requirements for eligibility and documentation must be met.

A. When a sibling of the identified client has specific behavioral health care needs and requires intervention targeted for those needs, (e.g., individual therapy, medication management, home-based treatment, and therapeutic supports such as out of home respite), a separate CSA service request must be made and authorization provided for that specific youth. *Siblings may not be served under the identified client's name for individual services*.

B. When a parent of the identified client has unmet behavioral health care needs that specifically impact the child's functioning and progress, CSA can only be accessed after all community agency referrals and private insurance/resources have been exhausted. *The ICC record must contain documentation of other resources that were explored including referrals to community agencies and the reason for use of CSA funding.*

ICC Termination

1. Members of the ICC Youth and Family Team shall develop a discharge/transition Plan of Care for after-care following termination of ICC services. It is the responsibility of the team, which includes the Lead Case Manager, to plan for discharge so that there are no lapses in services. This Plan of Care can be used to request services after ICC ends. The end-date for community-based services approved as part of the youth's Plan of Care during the ICC intervention may extend for up to 15 days beyond the ICC termination date if funds are available. The Lead Case Manager will amend the purchase order request to utilize the additional 15 days.

2. The Lead Case Manager has the primary responsibility for ensuring that any necessary authorizations for additional CSA funded services have been completed prior to the end of ICC services. Requests for service should be submitted to CSA no later than 15 business days before the end of ICC. Additionally, the Lead Case Manager assumes the responsibility for service oversight, including any communication with service providers, after the ICC termination date. If additional services are not authorized before the services expire which will lead to a lapse in services, the Lead Case Manager is responsible for communicating with the provider to terminate services, pending reauthorization.

MEMO TO THE CPMT
July 29, 2022

Administrative Item A-4: Expansion of Case Support Services to Private Provider

ISSUE: That sufficient Case Support capacity is available to meet intensive behavioral health care needs of at-risk youth and their families in our community.

BACKGROUND:

CSA was originally designed to support mandated agency services where case management is included in the responsibilities of the agency staff such as child welfare practitioners, special education liaisons, or probation officers. As service delivery has moved from mandated, system-involved youth to serving more youth on a voluntary basis with earlier identification, available case management capacity has not kept pace. Although the CSB has grown case management capacity in the Resource Team, there are times when through high demand, turnover, and competing staffing needs, a case manager may not be available. The school division also provides a significant amount of case management for youth who have been identified as needing intensive intervention. Early identification of at-risk youth by school staff have significant benefits. However, social workers' workload and responsibilities may mean that taking on CSA case management duties is beyond their means. COVID has added to the existing need for increased case management capacity. Increased needs and increased acuity for youth must be matched by having sufficient staff to connect youth with existing services.

The Office of Comprehensive Services (OCS) approved funding for a service called Case Support.

> Case Support definition: Service may be purchased from a public child serving agency and includes basic case oversight for a child not otherwise open to a public child-serving agency, for whom a case manager is not available through the routine scope of work of a public child-serving agency, and for whom the worker's activities are not funded outside of the State Pool. Services may include administration of the CANS, collection and summary of relevant history and assessment data and representation of such information to the FAPT; with the FAPT, development of an IFSP; liaison between the family, service providers and the FAPT.

In an email from Scott Reiner, Executive Director of the Office of Children's Services (OCS), our local CSA program was given permission to proceed with contracting with a private provider. Mr. Reiner agreed that such action was consistent with the responsibilities of the CPMT and outlined several considerations *(with local response in italics)*:

- That the provider be trained and certified in the CANS but that public agency staff enter the CANS in the state system, CANVAS. *Our FRU analyst can complete this task.*
- That local policy address potential conflict of interest where a private provider serving as the case manager is not neutral in referring youth to other provider organizations when appropriate. *CSA can contract with a provider that does not offer a range of community-based services themselves. UR staff also review all service requests and can monitor neutrality.*
- That public agencies such as the CSB continue to fulfill their role as the behavioral health care representative. That youth and families have a "home" within public agency work. *Cases may be*

assigned to private providers as an overflow when CSB does not have capacity. It is possible that this option may be helpful when youth do not clearly fit within any one agency's scope.

Recommendation: The CSA Management Team supports expanding Case Support to specific Private Providers. If the CPMT approves, the CSA Management Team supports recruiting a private agency specializing in serving multi-cultural members of our community to increase our system's capacity and outreach to underserved populations. A second provider could also be recruited perhaps with expertise in working with youth with developmental disabilities/autism. The need for Case Support by private providers is difficult to estimate. CSA requests no specific cap on the number of referrals. Each provider would be asked to train 2-3 staff to provide Case Support, permitting their staff to have mixed caseloads and accept Case Support as the need arises.

The CSA Management Team also supported some additional guidelines for this expansion:

1. Private providers would not manage residentially-placed youth. Case Support for private providers would be for community-based interventions only. CSB would continue to manage residential cases.
2. The current Agreement for Purchase of Services for Case Support would be used for any entity offering the service using existing rate structure, monitoring and oversight processes.
3. The CSA program will assume the role of managing assignment of cases to private providers.

FISCAL IMPACT:

The established monthly rate for Case Support is $757 for FY23 averaging out to approximately 10 hours of service per month using a standard rate for home-based services. Private Provider Case Support for 45 students, across a full year would be an impact of $408,780. The cost of the associated community-based, CSA purchased services is approximately $234,206. The full year impact of expanding Case Support through the use of private providers with expertise in certain populations is estimated at $642,986 of which approximately $494,713 would be reimbursed by the state at the community-based match rate of 76.94%. Funding is available for Case Support within the existing FY 2023 CSA appropriation approved by the Board of Supervisors.

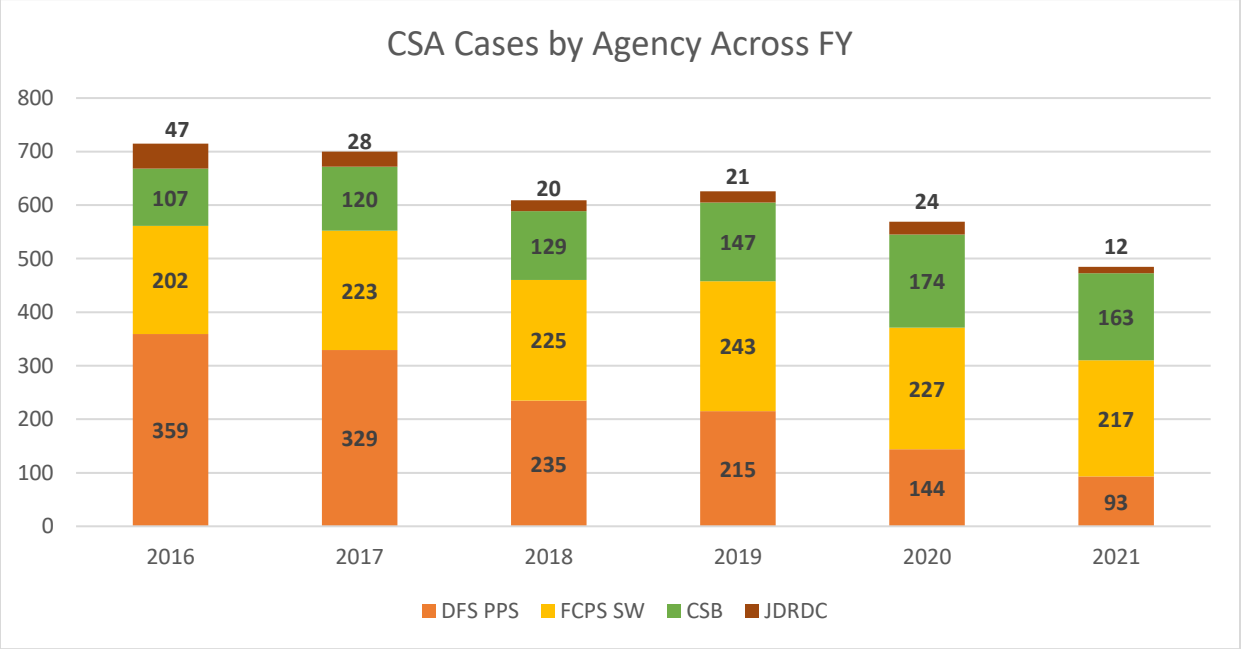
ATTACHMENT: Local Policy Manual – Case Support

STAFF:

Janet Bessmer, CSA Director

Additional Justification for Case Support Expansion

- The number of youth referred to CSA has been declining over the past two years. The referrals are lower from programs like CPS, PPS and the court.
- CSB case managers and FCPS SWs carry a large number of "voluntary" behavioral health care cases for CSA-funded services (3 year annual average = 390)
- The standard established for a full-time mental health CSA case manager is a caseload equivalent of 15 cases.



Eligibility for MH Case Management using CANS ratings

CANS criteria have been established for MH Case Management using ratings on the CANS Risk Behavior and Emotional/Behavioral Scales. The criteria consists of one actionable rating on Risk and two actionable scores on Emotional/Behavioral. Using FY21 CANS data with foster care youth removed, 267 youth out of 439 met the criteria for MH case management.

- 18 full time CSA case managers would be needed to manage that volume
- CSB currently has 9 case managers, is filling 3 vacancies and plans to add 3 new positions
- Approximately 3- 6 additional case managers from the private sector may be needed to meet the need for MH case management

Attachment: Local Policy Manual

Service Definition for ~~*CSB*~~ Case Support Service

The Case Support Service may be purchased ~~from a public child-serving agency and~~ includes basic case oversight for a child not otherwise open to a public child-serving agency, for whom a case manager is not available through the routine scope of work of a public child-serving agency, and for whom the worker's activities are not funded outside of the State Pool. Services may include:

- Administration of the CANS
- Assisting individuals and their families with access to services and supports
- Collection and summary of relevant history and assessment data and representation of such information to the FAPT
- Development of the IFSP/MAP for community-based services to include natural supports and transition planning as appropriate
- Liaison between the family and service providers
- Attendance and provision of behavioral health care expertise at any necessary FRM's and FPM's
- Quality assurance of service provision by monitoring direct service providers, and progress towards goals by maintaining regular contact with clients and team members
- Documentation of activities in agency electronic health care record in compliance with State Performance Contract, team practice and contract agreements
- Completion of the responsibilities assigned to CSA case managers and TBP participants in local CSA policy

Needs-based Criteria for Case Management/Case Support

Using the state mandatory uniform assessment instrument, the CANS, youth can be matched to the appropriate case management entity based on their needs rather than how they were referred to the system of care.

Criteria for CSB Case Management/Case Support
Youth who meet the CANS criteria on the Behavioral/Emotional and Risk Behavior subscales are eligible for Case Management/Case Support provided by the CSB. Other funding supports for the CSB provide for additional capacity to provide case management and serve as the lead case manager for CSA.

CANS criteria to define significant Actionable level of need by domain:
Behavioral/ Emotional Domain = Two 2s or two 3s
Risk Behavior Domain = One 2 or One 3 (exception: Intentional Misbehavior is excluded due to scoring concerns)

CANS criteria for CSB Case Management/Case Support:
Youth with significant Actionable needs under Risk Behavior with significant Actionable needs under the Behavioral/Emotional domain

Of the youth who are eligible, the CSB will provide Case Management/Case Support within agreed upon caseload and capacity data, except for:

- Youth who are currently in foster care
- Youth who are currently placed in residential for purposes of meeting their IEP (Res IEP only)
- Youth who are currently being served in the community by Child Protective Services (CPS), Protection and Preservation Services (PPS) and the DFS Kinship Unit
- Youth who are currently on probation

The CSB will prioritize acceptance of the following CSA-eligible cases that a) meet the CANS eligibility criteria for Case Support, 2) are not served by an agency listed above, and 3) meet at least one of the circumstances below listed in order of priority:

1. Youth who require discharge planning from mandated, state-funded psychiatric hospitalization.
2. Youth who are under consideration for residential treatment or a group home level of care and will be referred to FAPT who are currently receiving lead CSA case management from a school social worker, DFS PPS or kinship care staff, DFS court liaisons, or court diversion staff.
3. Youth who have been served by a mandated agency listed above, but the agency's involvement is scheduled to end and the youth will require ongoing behavioral health care supports. (Examples: diversion or probation is ending, CYF PPS is closing the case).
4. Youth who do not have any current system involvement. (Examples: direct parent referrals to CSA, private psychiatric hospital referrals) Youth who are receiving private day IEP services and require case management for community-based, ancillary services for clinical, non-educational needs occurring in the home and community.

MEMO TO THE CPMT

July 29, 2022

Administrative Item A - 5: Policy for Utilization Reviews and Billing Procedures

ISSUE: That the policy for utilization review reports and billing procedures be updated and reflected in the local policy manual.

BACKGROUND: The CSA program has had internal utilization review staff beginning in 2004. Utilization reviews are eligible for CSA pool fund reimbursement. Although the UR Analysts perform many activities to review and authorize services, our procedures are to bill for completed UR written reports only.

RECOMMENDATION: That the CPMT approve the additions and revisions to the CSA local policy manual for utilization review.

ATTACHMENT:
Proposed local policy manual revisions

INTERNAL CONTROL IMPACT: None

FISCAL IMPACT: None

STAFF:
Jeanne Veraska, CSA UR Manager

FAPT Reviews for Residential Placements (page 25)

When *FAPT develops* ~~an initial~~ a plan for residential or group home treatment, the initial funding approval period shall be for no more than 4 months, and subsequent funding approval periods shall be for no more than 3 months. The FAPT may also support community-based services and interventions deemed necessary and appropriate for the youth's transition back to the community.

1. For extension requests, an updated Case Manager Request for FAPT Meeting and other required documents ~~shall~~ *should* be submitted to the CSA office at least 15 business days prior to end of the authorization*. A gap in funding may result if the case manager does not allow adequate time for utilization review and FAPT scheduling.* ~~The complete and correct packet shall be provided to UR *immediately* upon receipt for use in completion of the UR report.~~
2. The FAPT must review the most recent (within 30 days) provider report and consult with the provider either in person or via telephone.

4.8 Utilization Management and Utilization Review

Each locality receiving funds for activities under the CSA shall have a utilization management process, ~~approved by the State Executive Council,~~ covering all CSA services. Utilization Management (UM) is a set of techniques used by purchasers of health and human services to manage the provision and cost of services through a systematic, data-driven process.

Utilization Review (UR) is a set of procedures for determining how well a program is meeting its stated outcomes. The review is a formal assessment of the necessity, efficiency, and appropriateness of the services and treatment plan for an individual and his/her family**.** UR also provides a method for assessing quality of services, performance improvement, and tracking of provider treatment outcomes across the CSA system. Utilization Management occurs at a variety of levels within the CSA system of care. Data about cost, types of services utilized, Medicaid funding, number of youth served, for example, are reviewed at the program level, CSA Management Team, and CPMT on a quarterly and annual basis. Components of UR of child-specific service plans are conducted by case managers, agency supervisors, team-based planning meeting members, and Intensive Care Coordinators (ICC).

The Fairfax-Falls Church CSA has a dedicated internal UM/UR staff whose role is to conduct child-specific reviews and to collect additional data for system-level analysis of utilization practices.

The Individualized Education Program (IEP) Team shall provide utilization review for IEP-required special education placements, to include a review of the child's progress toward the annual goals on the IEP and the extent to which that progress is sufficient to enable the child to achieve the goals by the end of the year (State User Guide for the Children's Services Act).

Utilization Review analysts have been delegated authority by the CPMT to authorize funding for CSA services, for those requests that meet state and local policy and ~~are in compliance with~~ *follow* local practice standards. Acting as agents on behalf of the CPMT, the utilization review staff in the CSA program are extended the immunity from liability as described in COV § 2.2-5205. Persons who serve on the team shall be immune from any civil liability for decisions made about the appropriate services for a family or the proper placement or treatment of a child who comes before the team, unless it is proven that such person acted with malicious intent**.**

Responsibilities of Utilization Review Staff

1. Review requests for services developed and supported by FAPTs and MDTs and provide service authorizations for those requests that meet state and local funding requirements;

2. Conduct timely utilization reviews according to a schedule in the approved Utilization Management plan;
3. ~~Contact lead case manager to review pertinent case history~~;
4. *Ensure completion of the* ~~Complete the~~ Department of Behavioral Health and Developmental Services' form for youth whose admission to a residential treatment facility was requested but not obtained for 30 days.
5. Conduct necessary record review and attend Team-based Planning Meetings, treatment team meetings, site visits, as needed to collect data and assess the service plan. Contact other agency members and providers for additional information and for coordination of care;
6. Prepare a written report regarding the results of the UR. Distribute the report to the lead agency case manager, ICC facilitator when applicable, the FAPT, and the CSA record;
7. Participate in Contracts' workgroups activities such as meetings, contract renewal discussions, and site visits;
8. Prepare summaries and analyses of utilization for the Management Team and CPMT;
9. Review and render decisions on case-by-case requests for use of non-Medicaid providers for residential and group home services.
10. Review and ensure that the criteria for Intensive In-home, Mental Health Skill Building, and Therapeutic Day Treatment/Partial Hospitalization services are met for non-Medicaid enrolled youth;
11. Review serious incident reports and follow-up with DPMM contracts' staff, lead case manager, providers, and other team members as needed.
12. Provide system feedback through regular communication with teams and through written reports regarding evaluation of the effectiveness and efficiency of purchased treatment services.
13. Evaluate facility and service quality compared to current best practices and licensure standards, encouraging the use of trauma-informed and evidence-based practices in written and verbal reports.
14. Monitor progress of services through comparison of CANS scores over time. Serve as CANS Super Users offering training and support to the system to enhance the reliable and valid use of the state mandatory uniform assessment tool.

7.3 Review and Approval Procedures (pg 55)

~~Our community~~ CSA has adopted a local utilization standard for the typical duration and types of services provided. These standards represent historical data and recommended episodes of care. These standards are reflected in requests and authorizations. Requests that exceed the standards will be considered based upon the documentation and justification provided.

Prior to approving a service authorization, Utilization Review Analysts ~~-~~consult and connect with the lead case manager and providers to provide an independent review inclusive of case conceptualization, assessments, treatment planning and goal progress, and recommendations. Family members may provide written information to the UR Analyst to prepare the report or a response to the report in writing that will be included in the youth's record. Families are not charged a parental contribution for the UR report.

Utilization reviews are conducted for the following service requests when meeting the :

- Long-term residential and group home requests – ~~at admission and every three months thereafter prior to discharge;~~ *when services are requested prior to initial placement and for extensions*
- Treatment foster care services- *review frequency based on level*; and

~~Intensive in-home services,~~ in-home services, intensive family preservation services, ~~intensive care coordination~~, mental health skills building, evidence-based practices provided in home to address family functioning, in-home respite, and therapeutic mentoring ~~monitored supervision, therapeutic supervision~~ and applied behavior analysis ~~every six months and when request exceeds 150 hours~~.

Although service planning and utilization reviews are individualized processes intended to meet the specific needs of a youth and family, the standard authorization for most community-based interventions is typically for a period of up to six months and 150 hours. Applied Behavioral Analysis (ABA) authorizations are often for up to 300 hours in a six-month period.

Any initial request for more than the standard duration per service, or any initial request for multiple home-based services that exceed 300 hours total should have a written UR report. The following types of service requests are appropriate for written utilization review reports, contingent upon staff capacity:

- Home-based interventions exceeding six months and 150 hours individually or 300 hours in combined interventions to determine that these additional services are essential to prevent out-of-home placement.
- For children in foster care, respite services that exceed ~~as per~~ the VDSS policy section 13.6 ~~for~~ up to 30 days per year. If more than 30 days per year is needed for a child with special needs, the reasons for the need for additional respite care should be documented. Respite care should not extend beyond 60 days per year.
- For children who are not in foster care, in-home and out-of-home respite services that exceed ~~up to~~ $5,000 and ~~no~~ more than 15 calendar days over a period of six months. Out-of-home respite may not exceed 14 consecutive days.
- Any extension of home-based services after the initial authorization; exception: transitioning from a non-EBP to any EBP (except ABA).
- ABA request(s) greater than 300 hours, either standalone or in conjunction with another in-home service.
- If a family-centered in-home intervention (i.e. FFT or FSS-IFPS) is in place via a sibling, that service is factored into generating a report if a subsequent sibling request for in-home is received

7.4 Service Authorizations for Family Members

CSA is a child-specific funding source. Service plans are intended to be comprehensive, family-focused, and child-centered to address the unique needs of the youth and family. Services can be offered to parent/caregivers and siblings in the team-based planning process if deemed appropriate, financially necessary, and to benefit the treatment planning for the identified child. Documentation that these conditions have been met must be included in service requests.

- CSA funding can be used for family-based interventions ~~where services and supports may be offered~~ for caregivers and siblings in support of and documented in the identified youth's IFSP/MAP developed through the team-based planning process.
- Services and supports provided directly to the parent/caregiver can be provided under the identified child's name for purposes of foster care prevention as documented in the IFSP/MAP.
- When a sibling has specific behavioral health care needs and requires intervention targeted for those needs, (e.g., individual therapy, medication management, home-based treatment, and therapeutic supports such as out-of-home respite), CSA funding must be requested and authorized for that specific youth. All CSA requirements for eligibility and documentation must be met.

8.1 Procedures for Utilization Review Approval of CSA funding (page 58)

Incoming service requests are forwarded ~~The FAPT coordinator will distribute requests~~ ~~directly to UR Analysts~~ *to the UR Manager or designee who will then assign the requests to UR Analysts* for review and service authorization per current procedures. Every attempt will be made for the same analyst *to continue with and review the same child/youth over the course of their requests with CSA and to review* sibling groups ~~for a comprehensive view sibling groups~~ for a comprehensive view of the family's package of services.

The review process may include:

• Review of the complete packet of documentation/IFSP/MAP;

• Review of the record of services ~~in Harmony and~~ *in the CSA and public agencies* ~~central files~~; and

• Contact with the case manager and any other relevant collateral sources to obtain any updates or additional information, as needed, and to discuss questions, ~~issues~~, *progress, barriers to progress* and concerns *related to treatment and service needs*.

CSA funding ~~Approval~~ for Medicaid-covered services (i.e., Intensive In-home services, *Therapeutic* Day Treatment/Partial Hospitalization *Program (PHP)* or Mental Health *Skills Building* supports) to ensure that documentation reflects that the child or youth meets the criteria established by DMAS regulations. This documentation shall include the signature and written approval of a licensed mental health professional.

Once provided to the UR Analysts, the UR Analysts ~~will have a maximum of~~ have five business days to complete the service authorization process. *If the review requires additional information, then the review may be pended. (see Approval Procedures for further details).* For requests requiring a written Utilization Report, UR Analysts will have a maximum of 10 business days from receipt to *UR* complete their review and ~~determination~~ *recommendations* about authorization.

Approval Procedures *for Community-based Interventions (CBI) and Foster Care Services*

1. If the requested services are approved by UR, UR analysts will document *the service authorization* in Harmony ~~the service authorization~~, and ~~send copies of~~ the authorization to the case manager*, copying the case manager's supervisor,* via secure email ~~as well as to the CSA central file.~~ A service authorization consists of a specific start and end date, the name of the approved service type(s*), the eligibility funding criteria for which the service is met,* and units of service necessary to generate purchase orders. Approvals will be designated by one of the following statuses:

a. Status: Approved

b. Status: **Approved with comments/recommendations** – The current request is approved, but in the notes UR staff may offer resources, suggestions and/or consultation about the service request. The comments may include directions that are relevant for any future requests. For example, application for a Medicaid waiver may be a required action step before any additional CSA funded services will be approved.

c. Status: **Approved with amendments** – UR staff will work collaboratively with the CM and/or *CM* supervisor to adjust/refine some aspect of the request such as number of hours, type of service. *However, the* ~~The~~ decision about the service authorization~~, however,~~ is made by the UR Analyst and is subject to an administrative appeal based on the criteria below.

2. For non-mandated youth, UR Analysts will verify the availability of funding for the services via internal CSA tracking procedures.

3. If the requested services are not approved based on the information provided, the UR Analyst must respond in ~~a secure email~~ *writing* to the case manager and supervisor one of the following statuses:

a. Status: **Pending** – Ex. if additional information is needed (report, documentation*, approved copay, updated/corrected CSA consent*), if the CANS needs to be updated/corrected*, follow-up with the family-based team about the most appropriate type of home based service, etc*. Timely response from the case manager/supervisor or other agency designee who can provide the information is necessary for disposition of the request. The case manager will have up to five business days from time of notification to provide the requested information or communicate a plan for getting the information along a different timeline. If the information is not received or the case manager has not communicated in that timeframe, UR will change the determination to "Status: Not approved" and notify the worker and supervisor via secure email that the request is no longer under consideration. ~~The request itself will be securely shredded. The CSA program will not keep copies nor return it to the worker.~~

b. Status: **Not approved** – UR staff will document the reasons for not approving the service citing SOC practice standards, level of care, CANS, missing information, etc.

c. Status: **Not eligible** – For situations where CSA law and/or state and local policy does not allow the service, such as Medicaid reimbursable expenses where no justification or inadequate justification has been provided to support "unavailable" or "inappropriate."

Approval Procedures *for Residential Services*

The FAPT, not UR, reviews and approves consent agenda items and residential placements. For residential requests, UR Analysts review the request and prepare a report for the FAPT with a recommendation, as outlined in 7.3. The FAPT reviews the UR report along with other documentation and discussion with the provider and family before making a decision. For approved residential requests, UR Analysts then work directly with the case manager to ensure completion of required documentation for Medicaid authorization, the parental agreement, and other necessary paperwork prior to completing an authorization note.

Decision Review Procedures

1. **Parent Notification**: Case managers shall advise all parents/legal guardians of the existing appeal process as well as the administrative reconsideration process and provide them with the written appeal procedure as part of their orientation to CSA, as per current policy.
2. **Administrative Reconsideration**: The UR Analyst will provide the case managers/supervisors with the reason that the service request was "Not approved," "Not eligible" or "Approved with Amendment." The category of UR decision will determine the most appropriate type of decision review process:

a. For **Not Eligible**: Administrative reconsiderations are reviewed by the CSA Program Director within three business days of CM written request. The CM's CSA Management Team member, or Falls Church CPMT member for Falls Church residents, may request a reconsideration of the CSA Program Manager decision by the CPMT Chair, which will be rendered within three business days of a written request. In the absence of the CSA Program Manager, a CSA Supervisor will be identified by the DFS Director in consultation with the CPMT chair.

b. For **Not Approved** and **Approved with Amendment**: A three-member panel, consisting of the CM's CSA Management Team member, or Falls Church CPMT member for Falls Church residents, the CSA Program Manager, and a third CSA Management Team member from an agency that is not serving the child, respond to written requests from the CM for administrative reconsideration within five business days. When reconsidering a decision of the UR Analyst to not approve a service identified on the IFSP/MAP, or to approve a service while amending the volume or duration of services specified on the IFSP/MAP, the panel shall invite the participants in the FAPT or MDT that developed the IFSP/MAP, and the UR Analyst that made the decision, to participate in its deliberations.

If the IFSP/MAP does not specify the number of hours or duration of a service, but the service authorization by UR defines those parameters, the worker may only request an administrative reconsideration; it is not eligible for a CPMT appeal. Decisions made through the administrative reconsideration process are final, unless otherwise covered under the local appeal policy.

- 3. **CPMT appeal process**: Any youth, parent, legal guardian/custodian, or representative of the agency holding legal custody of the youth has the right to follow the appeal process as outlined in section 4.4, page 25 of this manual for any services that are not approved or are amended. Case managers are encouraged to utilize the administrative reconsideration process first, when appropriate.

Amending the Service Authorization

CSA Case Managers may use the Amend the Service Authorization form to request changes to a service authorization in the following circumstances:

- Adjustment to the start and end dates;
- Change to the Service Code/Name within the same level of care;
- Update to the eligibility category for the approved service.

The request must be received in the CSA program prior to the original service end date. The request to change the authorization must reflect and be consistent with the original service request and not require a new service plan. UR Analysts are responsible for determining if the requested change can be made or if the worker must submit a new service request. If the UR Analyst does not amend the request, the case manager is able to submit a new service request. The Administrative Reconsideration process does not apply to amendments to the service authorization rather a new service request must be submitted.

Billing for Utilization Review Reports (NEW)

~~*Utilization reviews are authorized in accordance with CPMT approved policies. Utilization review reports may be completed prior to FAPT, contingent on subsequent FAPT review within 14 calendar days. Utilization review staff are authorized by CPMT to approve ICC assessments, contingent on FAPT review within 14 days.*~~

CPMT policy authorizes and permits pool fund reimbursement for UR reports completed in accordance with CPMT approved policies for utilization review. Local policy outlines for which services UR reports are to be completed and at what frequency. These UR Reports are eligible for CSA pool fund reimbursement without a specific authorization. The same standard fee is charged for each of the three types of completed UR report. Three service types require a written UR report: residential/group home, treatment foster care, and specific home-based services. The requested service determines which type of report is prepared and the mandate type to fund the report is based on the most recent eligibility determination.

The CSA information system provides a monthly list of all completed UR reports and generates an individual invoice per case. Only completed reports are eligible for reimbursement. Reports are available in the youth's CSA record and provided to the case manager and family. UR reports are also provided to the FAPT when reviewing initial requests and extensions for residential/group home services. An invoice for each report is generated for a flat fee per completed report. The UR Manager submits invoices to CSA Management Team members for their signature. Signed invoices are submitted to the DFS Fiscal Team for pool fund reimbursement. Pool fund reimbursement supports the utilization review positions in the CSA program support operating budget.

MEMO TO THE CPMT

July 29, 2022

Administrative Item A - 6: Policy and Practice Standards for Preferred Name and Pronoun

ISSUE: That youth served in the CSA System of Care are referred to by their preferred name and pronouns as best practice and policy.

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BACKGROUND: During the process of service planning for a family, staff questioned whether CSA has a policy about using the youth's preferred name and pronouns. The current System of Care Practice Standards include the guidance below:

Consideration will be given to:

• Learning styles, communication levels and language assistance needs and where possible, involved professionals will provide supportive accommodations so that the youth and family can actively and fully participate.

• Youth and/or participating family member(s) with disabilities, gender self-identification concerns, and/or relevant faith and cultural values and beliefs present so that these can be attended to in an informed and respected manner during all collaborations.

• Transportation/geography, presence or lack of financial resources and insurance constraints, age (transition age youth or young children) and time access (time of meetings/length of meetings), so that they do not create access barriers to the youth and family. When any are present, all participating members will work to mitigate the impact on providing support and services.

The CSB uses preferred names and pronouns following the administrative code/regulation regarding dignity for clients served by public entities:
https://law.lis.virginia.gov/admincode/title12/agency35/chapter115/section50/

FCPS also has policy Here on gender expansive, transgender students requiring that preferred names and pronouns are used.

RECOMMENDATION: The CSA Management Team supports the following policy changes:

1. The youth's legal name will be used on legal documents such as the Consent form. On other documents, the youth's preferred name and pronouns will be utilized.
2. The CSA program will add gender neutral options on forms and documents where possible when state reporting requirements are not impacted.
3. Youth served by CSA will receive gender-affirming programming and placements consistent with their gender identification, whenever possible.

4. CSA will add provisions for gender-affirming care to contract language.
5. The Practice Standards will be revised to clearly state that the youth's preferred name and pronouns will be used.

FAMILY ADVISORY BOARD AND YOUTH ADVISORY COUNCIL:
Both the Family Advisory Board and Youth Advisory Council members supported use of preferred name and pronoun for youth served by CSA.

ATTACHMENT: None

STAFF:
Janet Bessmer, CSA Director
Sarah Young, CSA

MEMO TO THE CPMT
July 29, 2022

Administrative Item A -7*:* Policy for CSA Standard Services: Emergency Supervision and Support for Youth in Foster Care

ISSUE: That children in foster care have access to services and supports in emergency situations.

BACKGROUND: Lack of capacity in therapeutic programs, disrupted placements, delays in admissions decisions, and other systemic challenges result in high needs youth waiting for placement. COVID staffing challenges have exacerbated this problem, and for children in foster care who have no family or caregiver, some youth have been temporarily housed in unapproved placements like local DSS offices or hotels, monitored round the clock by foster care specialists. Some youth are boarded in emergency departments or stay longer than necessary in acute psychiatric hospitals. To address this problem, the Governor established the Safe and Sound taskforce to eliminate youth in foster care from spending the night in government offices. OCS has recently affirmed the use of CSA funding to provide supervision and supports for youth in care in these situations.

The CSA Management Team in partnership with the DFS Children, Youth and Families division requests approval to amend the standard authorized services provided to youth in foster care to include Emergency Supervision and Support (ESS). ESS includes 1:1 supervision and other supports that are necessary to meet the youth's basic needs when they are in between approved placements or in a hospital or emergency department. The standard services are often referred to as "boilerplate" services that are approved for all youth in foster care by the FAPT when youth enter care. This long-standing practice permits a range of basic supports to be offered when needed with approval of the foster care supervisor. Pending CPMT approval, the CSA Management Team recommends inclusion of "Emergency Supervision and Supports" in the standard language to allow them to be accessed for up to 7 calendar days for up to 125 hours without additional CSA authorization. Services beyond this length of time will require utilization review and authorization.

RECOMMENDATION: That the CPMT approve a change in our policy to include emergency access to necessary supervision and support for children in foster care using the standard language approved by the FAPT.

ATTACHMENT: Local policy manual chart of standard services

INTERNAL CONTROL IMPACT: None

FISCAL IMPACT: Estimated cost per youth per episode is $10,000. In FY22, two youth were served.

STAFF:
Sarah Young, CSA
Kamonya Omatete, DFS

Services Eligible for Expedited FAPT Services Planning

FAPT reviews requests for services specified on the IFSP-EZ form and can provide expedited team-based service planning on a limited basis. Services are not authorized to begin prior to review of complete documentation by the FAPT.

3. For children in foster care and children at-risk of entering foster care served by the Department of Family Services Children, Youth and Families Division, the following services may be requested with standard language incorporated in the IFSP/MAP. The use of standard language incorporated in the IFSP/MAP or the IFSP-EZ to request services for children at-risk of entering foster care served by DFS CYF is limited to six months after the initial CSA service approval.

Service	Foster Care	CPS/PPS/Kinship*
Camp/Socialization/Recreation programs and activities	✓	✓
Summer youth employment programs	✓	✓
Youth & family travel costs for visitation, appointments and training related to the IFSP/MAP or foster care service plan (not for Medicaid or IV-E eligible expenses)	✓	✓
Parenting and anger management classes	✓	✓
Family Partnership Meetings	✓	✓
Translation/Interpretation services to support clinical services only	✓	✓
Court testimony (8 hours per subpoenaed provider per day per hearing; not for expert testimony)	✓	✓
Respite (in-home and out of home)	30 days/year maximum	Maximum of $5,000 and/or 15 calendar days over 6 months and not to exceed 14 consecutive days out of home
Non-Medicaid reimbursable medical expenses excluding behavioral health care services	✓	$1,000 annual maximum
Acute hospitalization not covered by Medicaid	14 consecutive days maximum per episode	NA
Emergency Supervision and Support	*7 days/125 hrs maximum per episode*	*NA*
Legal fees	✓	NA
Driver's education	✓	NA
School-related fees (excluding private school tuition)	✓	NA
Out-of-State public school tuition	✓	NA
Foster/adoptive home studies	✓	NA
Court-ordered evaluations/assessments from CSA-contracted providers	✓	NA
Tutoring	$3,000/year max	NA
***reference UR service authorization note for eligible dates of service**		

MEMO TO THE CPMT
July 29, 2022

CPMT Contract Information Item C-1: Out of State Residential Child Specific Contract Activity

ISSUE: That the CPMT receive regular reports on the CSA Management Team approvals of placements in out of state residential facilities. Since the last CPMT meeting, DPMM processed one (1) Child Specific Contract Request for out of state residential facilities.

Date Received by DPMM	Provider	Location	Medicaid Participating/ Single Case Agreement	Requesting Department	Barrier to Contract Pool of Providers	CSA MT Approval Date
6/6/2022	Millcreek of Pontotoc Treatment Center	Pontotoc, MS	No but considering Single Case Agreement	DFS-FC&A	Borderline IQ, run risk, self-injurious	6/13/2022

BACKGROUND:
As of January 29, 2021, the CPMT has delegated authority for the approval of out of state residential placements for youth to the CSA Management Team. For each month in which a contract is approved, a report of the contract activity is required by the CPMT to identify both new child specific contract placements and any existing child specific contracts that remain active. In the consideration of each contract placement request, all clinically appropriate Medicaid providers located in Virginia under Agreement for Purchase of Services (APOS) with the County were considered and were determined not appropriate due to the individual needs of the youth.

CURRENT SITUATION:
Since the last CPMT, there was one (1) new child specific contract approved by the CSA Management Team as noted above. In addition to the newly approved Child Specific Contract, there were a total of ten (10) active Child Specific Contracts for youth with out of state facilities as detailed below:

Provider	Location	Case Managing Agency	Barrier to Contract Pool of Providers	Date of Approval[1]
Devereaux - CIDDS (Kanner)	Pennsylvania	FCPS-MAS	IEP for Residential School under the category of Multiple Disabilities with physical aggression	5/1/2015 (CPMT)
Devereux-Brandywine	Pennsylvania	FCPS-MAS	IEP for residential School Setting. ASD and aggression	4/19/2020 (CPMT)
Benedictine School	Maryland	FCPS-MAS	IEP for Residential School Setting	1/24/2020 (CPMT)

1 Child Specific Contracts approved by the CPMT, prior to the delegation to the CSA Management Team, are noted accordingly.

Change Academy of the Ozarks (CALO)	Missouri	FCPS-MAS	IEP for Residential School references ADHD, RAD, Emotional Disability, and Learning Disabilities. VA facilities would not accept.	5/29/2020 (CPMT)
Chamberlain Intl School	Massachusetts	FCPS-MAS	IEP for Residential School	9/20/2020 (CPMT)
Justice Resource Institute (Glenhaven Academy)	Massachusetts	CSB	Diagnosis of ASD and physical aggression	3/22/2021
Maplewood School	Armenia, New York	FCPS-MAS	Parental Placement of student with IEP for Private Day School Setting. Contract for Education costs only.	9/09/2021
Latham Centers	Brewster, Massachusetts	FCPS-MAS	Prader-Willi Syndrome with severe aggression and other complicating medical issues.	9/20/2021
Judge Rotenberg Center	Canton, MA	DFS-FC&A	Include Intellectual Disability, Autism, ODD, ADHD, and a seizure disorder with a history of physical aggression towards others, property destruction, self-injury and elopement. Seven month stay at Commonwealth Center for Children and Adolescents.	2/14/2021
Sandy Pines Residential Treatment Center	Jupiter, Florida	DFS-FC&A	Young age, level of criminal offenses, and aggression	5/20/2022

ATTACHMENT: None

STAFF:
Barbara Martinez, DPMM

MEMO TO THE CPMT
July 29, 2022

Information Item I-1: June Budget Report & Status Update, Program Year 2022

ISSUE:
CPMT members monitor CSA expenditures to review trends and provide budget oversight.

BACKGROUND:
The Budget Report to the CPMT has been organized for consistency with LEDRS reporting categories and Service Placement types.

The attached chart details Program Year 2022 cumulative expenditures through June for LEDRS categories, with associated Youth counts. IEP-driven expenditures for Schools are separated out. Further information on the attachment provides additional information on recoveries, unduplicated youth count, and:

-Average cost per child for some Mandated categories
-Average costs for key placement types, such as Residential Treatment Facility, Treatment Foster Home, Education placements.

Total Pooled Expenditures: Pooled expenditures through June 2022 for FY22 equal $28.6M for 965 youths. This amount is a decrease from last year by approximately $2.8M, or 8.81%. YTD Pooled expenditures for FY21 equaled $31.3M for 1,003 youths.

	Program Year 2021	Program Year 2022	Change Amt	Change %
Residential Treatment & Education	$4,079,576	$4,598,762	$519,186	12.73%
Private Day Special Education	$17,923,068	$15,377,373	($2,545,695)	-14.20%
Non-Residential Foster Home/Other	$6,065,656	$5,286,083	($779,573)	-12.85%
Community Services	$3,307,217	$3,822,471	$515,255	15.58%
Non-Mandated Services (All)	$929,815	$461,974	($467,841)	-50.32%
Recoveries	($986,382)	($985,750)	$632	-0.06%
Total Expenditures	**$31,318,950**	**$28,560,913**	**($2,758,037)**	**-8.81%**
Residential Treatment & Education	126	98	(28)	-22.22%
Private Day Special Education	288	266	(22)	-7.64%
Non-Residential Foster Home/Other	340	320	(20)	-5.88%
Community Services	676	723	47	6.95%
Non-Mandated Services (All)	206	172	(34)	-16.50%
Unique Count All Categories	**1,636**	**1,579**	**(57)**	**-3.48%**
Unduplicated Youth Count	**1,003**	**965**	**(38)**	**-3.79%**

Note: The number of youths served is unduplicated within individual categories, but not across categories.

Expenditure claims have been submitted to the State Office of Children's Services (OCS) through June2022.

RECOMMENDATION:
For CPMT members to accept the June Program Year 2022 budget report as submitted.

ATTACHMENT:
Budget Chart

STAFF:
Timothy Elcesser, Xu Han and Usman Saeed (DFS)

NOTE:

Residential Treatment & Education increased by $519k with 28 fewer youths served. RTC enrollment PIT count is lower in FY22 vs FY21 (36 – 39). Average Residential Treatment & Education costs per youth have increased by 45% as compared to last year. Residential area overall cost is up, mainly due to increased Residential service and Residential education cost paid YTD.

Private day special education costs paid YTD have decreased by $2.5M with 22 fewer youths served. Average private day special education costs per youth have decreased by 7% as compared to last year.
PIT count in FY22 vs. FY21 (278 – 290) has also decreased by 12 youths

Non-Residential Foster Home/Other has decreased by $780k with 20 fewer youths served than in same period last year. Average Non-Residential Foster Home/Other costs per youth have decreased by 7% as compared to last year due to more youths are placed with relatives and resulting TFC costs and transportation costs are down. PIT count for TFC is almost at same level of FY21 (55 – 56).

Community Services increased by $515k with 47 more youth served year to date, average community services cost per youth has dropped by 8% as compared to last year.

Non-Mandated Services expenses have decreased by $467k with 34 fewer youths served, average non-mandated services cost has also decreased by 40%.

Program Year 2022 Year To Date CSA Expenditures and Youth Served (through June Payment)

Mandated/ Non-Manda	Residential/ Non-Residential	Serv Type Descrip	Local Match Rate	County & Foster Care	Youth in Category	Schools (IEP Only)	Youth in Category	Total Expenditures
Mandated	**Residential**	Residential Treatment Facility	57.64%	$1,482,257	53			$1,482,257
		Group Home	57.64%	$332,745	8			$332,745
		Education - for Residential Medicaid Placements	46.11%	$90,137	2	$1,483,967	24	$1,574,104
		Education for Residential Non-Medicaid Placements	46.11%	$135,479	3	$1,047,961	7	$1,183,439
		Temp Care Facility and Services	57.64%	$26,217	1			$26,217
	Residential Total			$2,066,834	67	$2,531,927	31	$4,598,762
	Non Residential	Special Education Private Day	46.11%	$494,800	9	$14,882,572	257	$15,377,373
		Wrap-Around for Students with Disab	46.11%	$231,212	56			$231,212
		Treatment Foster Home	46.11%	$2,996,224	90			$2,996,224
		Foster Care Mtce	46.11%	$1,047,587	114			$1,047,587
		Independent Living Stipend	46.11%	$278,281	35			$278,281
		Community Based Service	23.06%	$3,030,722	524			$3,030,722
		ICC	23.06%	$791,749	199			$791,749
		Independent Living Arrangement	46.11%	$732,780	25			$732,780
	Non Residential Total			$9,603,355	1052	$14,882,572	257	$24,485,927
Mandated Total				**$11,670,189**	**1119**	**$17,414,500**	**288**	**$29,084,689**
Non-Mandated	**Residential**	Residential Treatment Facility	57.64%	$101,647	6			$101,647
		Temp Care Facility and Services	57.64%	$724	1			$724
	Residential Total			$102,371	7	$0	0	$102,371
	Non Residential	Community Based Service	23.06%	$280,598	89			$280,598
		ICC	23.06%	$79,005	76			$79,005
	Non Residential Total			$359,603	165	$0	0	$359,603
Non-Mandated Total				**$461,974**	**172**		**0**	**$461,974**
Grand Total (with Duplicated Youth Count)				**$12,132,163**	**1,291**		**288**	**$29,546,663**

Recoveries	**-$985,750**
Total Net of Recoveries	**$28,560,913**
Unduplicated child count	965

Key Indicators

Cost Per Child	**Prog Yr 2021 YTD**	**Prog Yr 2022 YTD**
Average Cost Per Child Based on Total Expenditures /All Services (unduplicated)	$31,224	$29,597
Average Cost Per Child Mandated Residential (unduplicated)	$45,297	$58,958
Average Cost Per Child Mandated Non- Residential (unduplicated)	$30,196	$28,177
Average Cost Mandated Community Based Services Per Child (unduplicated)	$4,938	$5,784
Average costs for key placement types		
Average Cost for Residential Treatment Facility (Non-IEP)	$20,288	$27,967
Average Cost for Treatment Foster Home	$30,380	$33,291
Average Education Cost for Residential Medicaid Placement (Residential)	$40,207	$60,542
Average Education Cost for Residential Non-Medicaid Placement (Residential)	$76,889	$118,344
Average Special Education Cost for Private Day (Non-Residential)	$62,233	$57,810
Average Cost for Non-Mandated Placement	$4,514	$2,686

Category	Program Year 2022 Allocation	Year to Date Expenditure (Net)	Percent Remaining
SPED Wrap-Around Program Year 2022 Allocation	$694,188	$219,213	68%
Non Mandated Program Year 2022	$1,630,458	$389,317	76%
Program Year 2022 Total Allocation	$42,187,551	$28,560,913	32%

MEMO TO THE CPMT

July 29, 2022

Information Item I -2: Development of the Human Services Legislative Issue Paper

ISSUE: That members of Boards, Authorities and Commissions (BACs) have the opportunity to review and contribute toward the development of the HS Legislative Issue Paper for Board of Supervisors' consideration

BACKGROUND: Each year the Board of Supervisors and County Executive reach out to Boards, Authorities, and Commissions (BAC) for their participation in shaping the County's legislative package. Board members are invited to begin reviewing the 2023 Human Services Issue Paper in preparation for further discussion at your upcoming meeting in July.

As part of this review, consider which items your BAC would like to continue to support in their current form for the 2023 General Assembly and identify any revisions or updates for items which need modifications for 2023. In reviewing existing positions, board members may want to consider the following:

- Have any **circumstances changed** such that the position has changed;
- Are there **new statistics** to support the position;
- Is there **better and/or new information** that further supports your argument;
- Did any **passed or proposed legislation from the last session** create a new priority.

New items supported by the CPMT must be submitted for each proposed new position tatement. It is critical that the CPMT provide detailed background information for these new items, which will be provided to the Board of Supervisors for vetting at Legislative Committee.

ATTACHMENT: DRAFT 2023 Fairfax County Human Services Issue Paper

STAFF:
Janet Bessmer, CSA

ATTACHMENT I

Draft 2023 Human Services Issue Paper – Items to be Reviewed for Updates/Revisions

DRAFT 2023 Fairfax County Human Services Issue Paper

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Draft 2023 Human Services Issue Paper – Items to be Reviewed for Updates/Revisions

DRAFT 2023 Fairfax County Human Services Issue Paper

Note: Please ensure that all track changes are by a single author (i.e., one name/color), reflecting an agency-level response.

NCS TO REVIEW, INCLUDING UPDATING STATISTICS

The Human Services Issue Paper is a supplement to the 2023 Fairfax County Legislative Program as the Fairfax County Board of Supervisors has long recognized that investments in critical health, housing, and human services programs are essential to maintaining a healthy and vibrant community that provides all residents an equitable opportunity to thrive.

As the nation continues to experience the various stages of the COVID-19 pandemic, substantial and sustained investments in health, housing, and human services remain essential in addressing the challenges facing Fairfax County. While there are signs of economic improvement, significant needs remain, demonstrating that many residents are still struggling – in particular, the pandemic disproportionately impacted communities of color, people with disabilities, low-income residents, and those experiencing vulnerability pre-pandemic will likely face the greatest challenges in recovering. In addition to the financial toll, the disruption, isolation, and stress caused by the pandemic impacted residents of all ages, races, ethnicities, and socioeconomic statuses. Services must be administered equitably to avoid exacerbating disparities in Fairfax County, while ensuring all residents have financial security, stable housing, and the opportunity to thrive. Further, effective and equitable health, housing, and human services, will ensure strong economic growth in the community and a resilient future for all residents.

Although Fairfax County has one of the highest median household incomes in the nation, significant and complex needs are prevalent in this community. Over 68,000 residents live in poverty and over 266,000 residents (23.5 percent) earn less than the living wage needed to afford basic expenses in this high cost-of-living area. In addition, negative impacts on income, employment, and health are pervasive, and disparities specific to certain racial groups and neighborhoods have been identified.

Historically, the state has underfunded health, housing, and human services, which puts enormous pressure on localities to fund critical services and new state mandates with local revenues. The $4.3 billion in federal relief funding the Commonwealth has received provides an unprecedented opportunity to address community needs magnified by the pandemic, including affordable housing, substance use disorder, mental health services, early childhood, health care, economic self-sufficiency, and home and community-based services for older adults and people with disabilities. As those needs existed long before the pandemic, even this substantial federal investment cannot solve decades of inadequate funding. However, such funding can place the state on an important path towards investing in critical core services while committing to utilizing sufficient state funding going forward to build on these important investments.

Strong partnerships between the Commonwealth and local governments are essential in addressing the pandemic's lingering impact and the diverse needs in our communities. This can be accomplished by making policy and budgetary decisions that:

- Invest in initiatives that offer all residents access to opportunities that equip them for lifelong success;
- Support residents experiencing vulnerability so they can live independent lives to their fullest potential;
- Address racial and social inequities that have created systemic and institutional barriers; and,
- Create evidence-based, outcome-driven programs that are innovative, incorporate best practices, and adapt to localities' unique needs.

Priorities

Affordable Housing and Homelessness Prevention TO BE REVIEWED BY CSB, DFS, DSB, HCD, AND COMMISSION FOR WOMEN

Support state funding and actions to increase the availability of affordable housing options and prevent homelessness, including expanded investments in tools and programs to address affordable housing needs, particularly in high cost-of-living areas like Northern Virginia, and to mitigate evictions resulting from the economic impacts of the COVID-19 pandemic.

Affordable housing is critically important for all Virginians, but obtaining it is particularly challenging in Northern Virginia, where housing is increasingly out of reach for low- and moderate-income earners. Fairfax County is already experiencing a deficit of 31,000 affordable rental homes, and the gap between the need and the supply will grow considerably without new approaches for expanding housing availability and affordability. It is anticipated that 15,000 net new units affordable to households earning 60 percent of area median income and below will be needed by the year 2034. Development and preservation of affordable housing is most critical for small families, individuals with disabilities, and seniors.

The devastating economic effect of COVID-19 has exacerbated this looming crisis, placing many individuals and families at risk of eviction in Fairfax County, including communities of color who are disproportionately impacted by the pandemic. Prior to the pandemic, 45 percent of Fairfax County renters were already cost-burdened and spent at least 30 percent of their household income on rent. Cost-burdened renters who have lost jobs or had their incomes reduced as a result of the ongoing economic upheaval face greater barriers in paying for housing, making them more vulnerable to evictions. While there has been some short-term rental assistance funding and moratoriums to prevent evictions, the pandemic's financial impact will have long-term and pervasive consequences. Therefore, new substantial and sustained federal and state investments in programs and resources that enable renters to keep their housing is essential in preventing an eviction crisis and a resulting surge in homelessness in the community. Funding to mitigate the impacts of the pandemic on affordable housing must be in addition to the sizable resources already needed to address the existing affordable housing crisis in Northern Virginia.

The Commonwealth should:

- Support substantially increasing funding for the Virginia Housing Trust Fund to $125 million, as well as increasing the funding cap that each development can request. This is essential to create and preserve affordable housing and reduce homelessness in Northern Virginia, where housing affordability poses substantial challenges for the economic competitiveness of the region, creating potentially negative impacts to the Commonwealth overall.
- Expand resources available to ensure legal assistance and aid to tenants facing eviction, including outreach and prevention services for potential beneficiaries.
- Expand the pool of resources available for down payment assistance, as down payment costs are a major barrier to homeownership for low- and moderate-income earners.
- Enhance and create more state-funded housing tax credits and rental assistance programs for individuals with disabilities and people experiencing homelessness, such as the Livable Homes Tax Credit, State Rental Assistance Program (SRAP), Virginia Homeless Solutions Program (VHSP), and previously provided Housing Choice Vouchers.
- Increase funding for permanent supportive housing units (allocated based on the size of the population served) for individuals with severe mental illness, substance use disorder, and developmental disabilities.

- Consider changes to state law to protect residents of mobile home parks, including more assistance with relocations, expanded notification requirements (for both tenants and localities), and increased timelines. *(Updates and reaffirms previous position.)* *(Position on state support for affordable housing shared by the region.)*

Behavioral Health, Public Safety, and the Criminal Justice System TO BE REVIEWED BY CSB AND COMMISSION FOR WOMEN

Support sustainable funding, allocated based on localities' needs and population size, for public safety and mental health services that connect people who come into contact with the criminal justice system for non-violent offenses to treatment.

Law enforcement officers have often been the first responders when an individual is in a mental health crisis; the Fairfax County Police Department responded to nearly 10,000 mental health-related calls in calendar year 2020. Such calls, at times, can lead to incarceration for non-violent offenses precluding individuals from receiving appropriate treatment for behavioral health issues. Fairfax County identifies various points at which individuals may be diverted from potential arrest and incarceration to community-based services. Efforts are also underway to create co-responder teams, comprised of both behavioral health and law enforcement professionals, to enhance the County's response to behavioral health crisis calls.

People with mental illness, substance use disorders, and/or developmental disabilities receive needed treatment services and supports, avoiding the cycle of criminal justice involvement. Additionally, it is significantly less expensive to provide services in community-based settings than it is to deliver behavioral health services in a detention facility.

Fairfax County continues to use local revenues for Diversion First, a Countywide initiative to provide alternatives to incarceration for people with behavioral health issues who come into contact with the criminal justice system. The program has already had a significant impact – since 2016, more than 2,400 people have been diverted from potential arrest. Though the average daily population has decreased since FY 2008, the medical complexities of inmates have increased, with complex substance use and mental health disorders becoming more common. Successful expansion of Diversion First will depend on adequate state investments in behavioral health services (and accompanying court and public safety resources) to:

- Provide full funding for the Commonwealth's System Transformation, Excellence and Performance in Virginia (STEP-VA) Crisis Services and for Marcus Alert implementation (enacted during the 2020 General Assembly (GA) Special Session) *(see also page 11)*;
- Increase the availability of community-based crisis services and local psychiatric beds for people with mental health issues;
- Provide additional case management resources to expedite the medical clearance process for individuals in need of psychiatric hospitalization;
- Enhance reintegration and discharge planning services for youth and adults at high risk of rapid re-hospitalization or re-offending *(see also page 12);*
- Increase funding for mental health services and substance abuse treatment for individuals incarcerated for offenses that make diversion programs unavailable to them;
- Remove barriers in order to facilitate the exchange of health information of individuals among law enforcement, the court system, CSBs, health care providers, and families and guardians;
- Support the expansion of specialty courts and dockets;
- Provide Crisis Intervention Team (CIT) and Mental Health First Aid training to law enforcement personnel, dispatchers, Fire and Rescue, jail personnel, and health and human services staff to

educate those interacting with individuals with developmental disabilities, substance use disorder, and mental illness;

- Improve the screening, assessment, and treatment of incarcerated individuals' mental health and substance use disorders by gathering uniform system level data; and,
- Provide adequate funding for forensic discharge planning and post-incarceration services to remove the barriers to community reentry. *(Updates and reaffirms previous position. See also the Courts position in the 2022 Legislative Program.)*

Substance Use Disorder TO BE REVIEWED BY CSB, HEALTH, AND LTCCC

Support increased capacity to address the Commonwealth's ongoing substance use disorder epidemic through community-based treatment (including detoxification, medication-assisted, residential, and intensive outpatient programs) and innovative efforts to limit the supply of opioids. Also, support coordinated strategies to meet the growing need for substance use disorder services that target specific high-risk age groups. In particular, innovative approaches to prevention (such as expanding county cigarette taxing authority to include e-cigarettes) and nicotine addiction treatment are necessary to address the vaping crisis that is affecting teens and young adults at an alarming rate.

Across Virginia, the statewide number of opioid overdose-related deaths continues to exceed the number of deaths due to motor vehicle accidents. Alarmingly, hospitals in the Fairfax Health District reported a 35 percent increase in the number of emergency room visits for opioid overdoses (including heroin and non-heroin) in 2020 relative to 2019. The number of such visits in the first half of 2021 is trending higher than the same period in 2020, raising concerns that the upward trend seen in 2020 may continue in 2021. This indicates that the opioid epidemic will continue to profoundly impact Fairfax County, and adequate resources and innovative strategies will be needed now more than ever. The 2021 GA took a helpful step by enacting legislation to establish the Opioid Abatement Authority, which will administer a significant amount of the moneys received from opioid litigation settlements for the purposes of treating, preventing, and reducing opioid use.

Another concerning trend is the widespread use of e-cigarettes, which have been the most used tobacco product among youth since 2014. Though e-cigarettes became popular because they have been considered less harmful than regular cigarettes, the discovery of severe respiratory illness in otherwise healthy young people as a deadly complication of vaping has raised alarm throughout the US.

While the Commonwealth of Virginia has taken action to combat these issues, including efforts to control the supply of opioids and increase the age to purchase all tobacco products to 21, significant challenges still exist. Complementary strategies, including well-funded, sustained intervention and education efforts, should be designed to support teens and young adults, many of whom may require specialized care to combat addiction. An e-cigarette tax could be a particularly helpful prevention tool, as research shows taxing tobacco is one of the most effective ways to reduce use, especially among the youth population. *(Updates and reaffirms previous position.)*

Position Statements

Medicaid Waivers TO BE REVIEWED BY CSB, DFS, DSB, AND LTCCC

Support state funding and expansion for Virginia's Medicaid waivers that provide critical home and community-based services for qualified individuals. Also, support increased funding for developmental disability (DD) Medicaid waivers and slots, to provide appropriate community services and ensure the Commonwealth fulfills its responsibility to implement the federal settlement agreement.

Medicaid funds both physical and mental health services for low-income children and parents, pregnant women, older adults, and people with disabilities. It is funded by the federal and state governments and administered by the states. Federal funding is provided based on a state's per capita income – generally, the federal government shares 50 percent of the cost of Virginia's Medicaid program (the exception is that under the recent Medicaid expansion the federal share is higher for newly eligible populations, but that does not affect waiver rates). Because each dollar Virginia puts into the Medicaid program draws down a matching federal dollar, what Medicaid will fund is a significant factor in Virginia's human services spending. However, states set their own income and asset eligibility criteria within federal guidelines.

Each state also has the discretion to design its own Medicaid service program. Virginia offers fewer optional Medicaid services than many other states (in addition to federally mandated services). Medicaid waivers allow states to "waive" the requirement that an individual must live in an institution, or that a service must be offered to the entire Medicaid population, to receive funding.

Medicaid waivers are an integral component of the Commonwealth's settlement agreement with the US Department of Justice (DOJ) – the state redesigned waivers for individuals with DD as part of its shift from an institution-based system to a community-based system. As a result, the Commonwealth has mandated a significant number of new requirements to the CSBs. The number and types of waivers are set by the GA. Long, growing waiting lists demonstrate the barriers that exist in the Commonwealth. Current Virginia waivers include: Commonwealth Coordinated Care (CCC) Plus, Community Living (CL), Family and Individual Supports (FIS), and Building Independence (BI). Waivers fund services such as personal assistance to live independently in a home, residential and employment services, environmental modifications, assistive technology, nursing services, and other therapeutic services which support individuals with severe disabilities to live as independently as possible in their community.

Fairfax County supports the following adjustments in Medicaid waivers:

- An increased number of DD Medicaid waiver slots to meet, at a minimum, the Priority One waiting list, which averages over 3,000 annually in Virginia.
- Automatic rate increases, including an increase in the Northern Virginia rate differential.
- Improvements to the process for negotiating the approval and re-approval of customized rates for individuals with intensive behavioral and health needs who cannot be adequately served through the standard DD waiver rate structure.
- Expansion of home and community-based services by incorporating the Community First Choice (CFC) option into Virginia's 2022 Medicaid state plan.
- Maintenance of Olmstead rights for people with disabilities and older adults to remain in the community following hospitalization for medical crises, including COVID-19 and related conditions.
- Ensuring a living wage for personal care attendants, consumer-directed personal assistants, respite care workers, and other caregiving roles that are funded through Medicaid waivers.

- Enhancement and preservation of the CCC Plus Waiver, and elimination of the weekly 56-hour cap on personal care services.
- Restoration of respite hours that were reduced from 720 to 480 in 2011. Respite care allows caregivers to better manage crises, such as the COVID-19 pandemic (if unused, there is no cost to the state).
- Fully funded reimbursements for nursing and behavioral consultation, training, monitoring, and supports.
- Increased state funding to support a sustainable, well-trained workforce in residential, employment and day support settings, including higher reimbursement rates to hire and retain professional nurses.
- Expansion of Regional Education Assessment Crisis Services and Habilitation (REACH) in-home crisis supports, access to appropriate intensive residential support options, and community-based crisis services for individuals with disabilities. *(Updates and reaffirms previous position.)*

Children and Families

Children's Services Act (CSA) **TO BE REVIEWED BY DFS**

Support continued state responsibility for funding mandated CSA services on a sum sufficient basis. Oppose changes to CSA that shift costs to local governments, or disrupt the responsibilities and authorities assigned to the County by CSA. Also, support the current structure, which requires that service decisions are made at the local level and are provided based on the needs of each child, ensuring that service expenditures are approved through local processes.

CSA provides care coordination and funding for services to children who: have serious emotional or behavioral problems; need residential care services; need special education; or, receive foster care services. It is a state-local partnership requiring an aggregate match of approximately 46 percent in Fairfax County. Children receiving certain special education and foster care services are the only groups considered mandated for service, and sum sufficient language ensures state and local governments provide funding necessary for such youth. As a redesign for the provision of behavioral health care services occurs at the state level to include changes to the state's Medicaid plan, the County should support policy alignment with CSA and continued local decision-making. *(Updates and reaffirms previous position.)*

Child Care **TO BE REVIEWED BY NCS**

Support state child care funding for economically disadvantaged families not participating in Temporary Assistance for Needy Families (TANF)/Virginia Initiative for Education and Work (VIEW), and support an increase in child care service rates. Also, support maintaining Fairfax County's local permitting process for family child care providers serving four or fewer non-resident children.

Research shows that the financial independence of parents is jeopardized when affordable child care is out of reach, and without subsidies, working families with low incomes may not access the quality child care and early childhood education that helps prepare young children for kindergarten (families in Fairfax County receiving subsidies have an annual median income of nearly $30,000, while the cost of full-time care for a preschooler at a child care center ranges from over $15,000 to over $21,000 per year). Many of these families are "the working poor" who require assistance with child care costs to achieve self-sufficiency. Additionally, a state waiver from VDOE allowing Fairfax County to permanently increase program income eligibility above the current 250 percent of the federal poverty level (FPL) would help address the challenges families experience due to the high cost of living in Northern Virginia. *(Updates and reaffirms previous position.)*

ATTACHMENT I

Draft 2023 Human Services Issue Paper – Items to be Reviewed for Updates/Revisions

Early Intervention Services for Infants and Toddlers with Disabilities/Part C **TO BE REVIEWED BY NCS**

Support increased and sustainable funding and infrastructure for Part C Early Intervention, which is a state/federal entitlement program that provides services for Virginia's infants and toddlers with developmental delays.

The Commonwealth contracts with the Fairfax County Department of Neighborhood and Community Services to provide early intervention service coordination and therapeutic services for infants and toddlers with developmental delays in areas such as speech, eating, learning, social interactions, and movement (as part of the Commonwealth's compliance with the federal Individuals with Disabilities Education Act (IDEA) Part C grant). The benefits of early intervention continue to be supported by research, and the demand for services to eligible children continues to grow at a rapid pace (as more children are diagnosed with autism or born substance exposed), but rates have not increased in a decade. *(Reaffirms previous position.)*

School Readiness **TO BE REVIEWED BY NCS**

Support increased state resources and operational flexibility for early childhood education programs, including the Virginia Preschool Initiative (VPI), in order to eliminate barriers and allow localities to expand these critical programs. In Fairfax County, state VPI funding provides less than half ($7,327) of the cost of providing VPI services to a child in a Fairfax County community-based early childhood program (approximately $18,200), which is insufficient to expand the program under current requirements.

Increasing funding while providing flexibility, including to serve children in non-public school classroom settings, is essential (if Fairfax County were to use all available slots to serve four-year-old children in only public school classrooms, approximately 51 additional classrooms would be needed, creating a substantial capacity challenge). Providing VPI services in community early childhood programs, including centers and family child care homes, is key to addressing capacity challenges in public school settings. The GA's recent changes to the VPI program, such as the appropriation of Community Add-On funding for each child served in a community-based early childhood setting, and the authorization of family child care homes as service providers, have been instrumental in increasing the number of children served in community settings. Additionally, the GA's expansion of VPI eligibility to three-year-olds provides more sustained school readiness supports for children and better meets community need. Although the GA has made considerable progress, providing flexibility for teacher credentials and licensure in community early childhood programs would allow grant funding to be used equitably across all programs participating in VPI. Continuing to have an additional membership verification window to confirm VPI eligibility for families enrolling after the initial fall membership verification date allows improved access to this important program.

Research has increasingly shown the importance of high-quality early childhood education programs to children's cognitive and social-emotional development and their school success. Business and military groups, including the US Chamber of Commerce and Mission: Readiness, a coalition of retired military leaders, have cited potentially positive impacts on national economic security, linking early childhood education to the creation of a qualified workforce. *(Updates and reaffirms previous position.)*

Older Adults and People with Disabilities

Independence and Self-Sufficiency for Older Adults and People with Disabilities **TO BE REVIEWED BY DFS, DSB, LTCCC AND NCS**

Support funding for programs that promote the independence, self-sufficiency, and community engagement of older adults and people with disabilities. Also, support additional funding for home care workers and resources for family caregivers.

Services to keep older adults and adults with disabilities in their own homes (such as personal assistance, nutrition and home-delivered meals, transportation, service coordination, adult day/respite supports, and resources for family caregivers) provided by the twenty-five Area Agencies on Aging (AAAs), community-based organizations, and state agencies, save Virginia taxpayers money while helping older Virginians function independently, decreasing the risk of inappropriate institutionalization, addressing social isolation, and improving overall life satisfaction and mental health. Additionally, critical Chore and Companion Services assist eligible older adults and people with disabilities with activities of daily living (such as getting dressed, bathing, housekeeping, and laundry). *(Updates and reaffirms previous position.)*

Adult Protective Services (APS) **TO BE REVIEWED BY DFS AND LTCCC**

Support state funding for additional APS social workers.

APS conducts investigations and protects older adults and incapacitated adults from abuse, neglect, or exploitation through the provision of casework services, home-based care assessments and coordination, and Medicaid and Auxiliary Grant pre-admission screenings. During FY 2021, Fairfax County APS received over 3,100 reports of adult abuse, neglect, and exploitation. As the older adult population has increased in Virginia, along with a corresponding demand for APS services, state funding for APS positions has remained stagnant. *(Updates and reaffirms previous position.)*

Long-Term Care (LTC) Workforce Needs **TO BE REVIEWD BY DFS, HEALTH, LTCCC, AND NCS**

Support legislation to improve the quality of LTC in Virginia's skilled nursing facilities, in order to ensure better health outcomes and quality of care for medically frail individuals, including older adults and individuals with disabilities.

LTC facilities, including nursing homes and skilled nursing facilities, provide medical and personal care to people who are unable to live independently. The quality of care in Virginia's nursing homes has long been an issue, with complaints ranging from insufficient staffing (Virginia is one of 16 states with no required staffing standards for either staff-to-resident ratios or a minimum number of direct care hours) to low Medicaid reimbursement rates for skilled nursing care (making recruiting and retaining highly qualified, well-trained staff difficult due to low wages and limited benefits) to stressful working conditions. On average, nursing homes in Virginia also have higher average acuity residents than nursing homes in most other states, meaning that they require a higher level of care and therefore more skilled staff hours. The COVID-19 pandemic has exacerbated many of these issues and magnified systemic problems.

After the GA considered legislation seeking to address these issues through staffing standards over the past two decades, the Joint Commission on Health Care completed a study and made recommendations on the overall nursing facility workforce and quality. According to the Commission's report, inadequate staffing also presents equity concerns, as statewide, facilities with fewer staff are also those with higher concentrations of Medicaid recipients and Black residents. For these reasons, it is essential that the Commonwealth take appropriate steps to improve the quality of LTC in Virginia's skilled nursing facilities, including increasing state funding, in order to ensure better health outcomes and quality of care in such facilities. *(Updates and reaffirms previous position.)*

ATTACHMENT I

Draft 2023 Human Services Issue Paper – Items to be Reviewed for Updates/Revisions

Health, Well Being, and Safety

Temporary Assistance for Needy Families (TANF) TO BE REVIEWED BY DFS

Support a continued increase in the TANF reimbursement rates in Virginia.

Following more than a decade of flat TANF rates, increases were provided in several recent GA sessions. Most recently, rates increased ten percent for all TANF households. However, current Virginia TANF benefit levels remain at or below 32 percent of the FPL for all family household sizes (up from 30 percent of the FPL). To further support this vulnerable population, the GA should continue to increase TANF payments. *(Updates and reaffirms previous position.)*

Domestic and Sexual Violence TO BE REVIEWED BY CSB, DFS, HCD, AND COMMISSION FOR WOMEN

Support additional state funding and efforts to increase the capacity for localities to implement culturally specific prevention and intervention services to eliminate domestic and sexual violence, including continued support for evidence-based, quality programs that provide education and rehabilitation for offenders to help end the cycle of violence and provide victims more choice in addressing safety concerns and housing needs. Also, support legislation to strengthen protective orders (POs), such as: requiring family abuse PO respondents to immediately surrender firearms directly to law enforcement; expanding the prohibition on knowingly possessing a firearm to include non-family abuse PO respondents; and, providing judges with greater discretion to extend and/or increase the time period of POs.

Research shows that domestic and sexual violence are major public health problems with serious long-term physical and mental health consequences, as well as significant social and public health costs. Witnessing domestic violence is considered an adverse childhood experience and can be extremely problematic for children, leading to depression, anxiety, nightmares, and academic disruptions; both female and male adults with lifetime victimization experience are significantly more likely to report chronic issues (including headaches, pain, and sleep problems) as well as long-term health problems (including asthma, diabetes, anxiety, depression, and alcohol/drug abuse). Investing in primary violence prevention is an essential strategy to decrease domestic and sexual violence and build safe, stable, and nurturing communities. *(Updates and reaffirms previous position.)*

Behavioral Health

STEP-VA and Marcus Alert TO BE REVIEWED BY CSB

Support funding, commensurate with the size of the population served, for implementation of STEP-VA (System Transformation, Excellence and Performance in Virginia), the Commonwealth's behavioral health transformation plan. Also, support additional state funding to improve the responsiveness and increase the capacity of the behavioral health system for Virginians of all ages, including programs that work in concert with STEP-VA core services, such as Marcus Alert, the Children's Regional Crisis Stabilization Program, and the Virginia Mental Health Access Program. Oppose the use of a local ability to pay factor in the distribution of CSB funds, which would penalize localities that make funding with local dollars a priority.

Building on behavioral health reforms made in recent years, the 2017 GA enacted STEP-VA, which mandates that CSBs provide new core services. As a result, all CSBs initiated the first two services, same day access to mental health screening and primary health care screening, before the July 1, 2019, deadline. The seven remaining services were originally mandated to begin by July 1, 2021, but implementation deadlines are now dependent on funding being allocated for each of the remaining seven core services. Funding has been allocated for peer support services, veterans' services, outpatient services, and the

Regional Crisis Call Center (which will be designated Virginia's 988 mental health and suicide crisis hotlines, a federal effort required to be in effect by July 16, 2022). Significantly, at no point during the four years of STEP-VA implementation has the Commonwealth provided adequate funding to implement any of the newly mandated services. The implementation of these mandates is further complicated by the nationwide shortage in the behavioral health workforce, compounded by salary compression for CSB staff and attrition rates, and impacted by the administrative burden of evolving regulatory requirements for service delivery. As additional mandates are implemented, the chasm between the funding the state provides and the actual costs of providing such services in Fairfax County continues to grow.

This funding gap is further exacerbated as the state continues to approve new behavioral health reform mandates that operate in tandem with STEP-VA, such as the recently established Marcus Alert (enacted during the 2020 GA special session). The law requires CSBs to create local protocols and establish either mobile crisis or community care teams. Fairfax County is already making significant local investments in community behavioral health services, including a one-time allocation of approximately $2.3 million, and $4 million in anticipated funding for the next fiscal year, to begin the local implementation of co-responder teams. Such teams, comprised of behavioral health and law enforcement professionals, align with the state's goals for Marcus Alert. However, it is important to note that the state has only allocated $600,000 to CSBs in the first phase of Marcus Alert implementation, and has allocated no funding for CSBs in the second phase of implementation (including the Fairfax-Falls Church CSB). When compared to the County's anticipated initial cost of approximately $6.3 million, it is clear that Marcus Alert will be underfunded from its inception, as was STEP-VA. Additionally, as has been the case with STEP-VA, each year that funding gap will likely widen as the funding burden on localities grows. Finally, as the development of the County's co-responder model was in process well before the passage of the Marcus Alert legislation, ongoing local flexibility should be part of any state implementation plan.

Sustaining such a high level of local funding while receiving inadequate support from the state, at a time that state mandates continue to grow, is becoming increasingly untenable. Localities that make funding these vital services with local dollars a priority should not be penalized for their efforts, and the County would strongly oppose the use of a local ability to pay factor in the distribution of CSB funds or for any state support of related behavioral health programs, such as Marcus Alert. *(Updates and reaffirms previous position.)* *(Regional position.)*

Emergency Responsiveness **TO BE REVIEWED BY CSB**

Support sufficient state funding for intensive community resources (such as Assertive Community Treatment and Discharge Assistance Planning) and intensive residential services, to alleviate the state hospital bed crisis and allow individuals to transition safely and expediently from psychiatric hospitals to community care. Oppose any state funding actions which disproportionately rely on local funding for service implementation.

In 2014, the GA passed legislation requiring state facilities to accept individuals subject to a temporary detention order if a bed in a private psychiatric facility cannot be located within the eight-hour timeframe of an emergency custody order. While this is designed to ensure that individuals in crisis receive emergency mental health treatment, it has also led to a shortage of state hospital beds. The Northern Virginia Mental Health Institute (NVMHI), one of the smaller state hospitals despite the large population it serves, continues to experience periods of 100 percent capacity. Although other state hospitals face similar capacity challenges, it is important to note that a major factor exacerbating capacity issues at NVMHI is the substantial increase in the diversion of individuals from other parts of the state (272 individuals in FY 2021, which represented a doubling of diversions to NVMHI from FY 2020). Fairfax County's ongoing local investments help ensure a robust continuum of community services, and allow for the Fairfax-Falls Church CSB to have one of the lowest per capita adult hospitalization rates in the Commonwealth (six residents per 100,000 compared to the statewide average of 15 residents per 100,000). However, the lack of sufficient

24-hour community-based services for individuals requiring intensive supervision and medical services continues to exacerbate the state hospital bed crisis.

DBHDS continues its efforts to improve and increase community-based mental health services to reduce the demand for emergency placements by shifting state funding from large mental health institutions to community-based facilities, where serving an individual is a fraction of the cost of hospitalization. Ensuring that such community-based services exist requires additional resources, and success cannot be achieved by simply shifting costs to localities. State funding is insufficient both for regional mobile response services to prevent the unnecessary hospitalization of children and youth, and for the intensive community resources that allow individuals to transition back to community care. Such local investments could help the state alleviate the hospital bed crisis by opening up more beds while also providing resources for CSBs to improve outcomes for individuals and the community. *(Updates and reaffirms previous position*.)

ATTACHMENT I

Draft 2023 Human Services Issue Paper – Items to be Reviewed for Updates/Revisions

Fairfax County 2022 Human Services Fact Sheet

Introduction

FACT SHEET STATS TO BE REVIEWED BY CSB, DFS, HCD, HEALTH, NCS, AND COMMISSION FOR WOMEN

Eligibility for public assistance programs that provide support for low-income residents is tied to a percentage (typically 100%) of the Federal Poverty Level (FPL). In 2019, there were over 68,000 Fairfax County residents (6% of the population) that earned less than 100% of the FPL (about $12,500 for an individual or $25,750 for a family of four).

However, the income needed to cover basic living expenses (food, housing, child and health care, transportation, etc.) in Fairfax County is far greater – MIT's Living Wage Calculator shows that a single adult needs over $41,000, and a family of four needs over $110,000.

In 2019, there were **over 68,000** Fairfax County residents that earned less than 100% of the FPL – 78% of Virginia's 133 localities had **fewer TOTAL residents** than Fairfax County had **residents living in poverty.**

Employment

- The unemployment rate in September 2021 was 2.7%, representing over 16,600 unemployed residents looking for work.

In 2019, there were **over 266,000** residents (24%) including approximately 80,000 children, living in households with incomes less than 300% of the FPL.

Housing

- In 2020, the average monthly rent for an apartment was $1,787**,** meaning a renter would need an income of $71,500 to afford it.
- In 2019, over 57,000 households (45%) of Fairfax County renters were cost-burdened (spent more than 30% of their income on housing). Over 8,500 cost-burdened renters were over the age of 65.
- There is an existing gap of 31,000 housing units affordable for current Fairfax County renters earning up to 80 percent of the Area Median Income (AMI).
- It is anticipated that 15,000 new affordable units for households earning 60 percent of the AMI and below will be needed for households moving into the County by the year 2034.
- There were 1,222 people who were homeless in the Fairfax-Falls Church community on January 27, 2021, the night of the 2021 Point-in-Time Count. Over the course of federal FY 2020, nearly 3,000 people relied upon the County's shelter system.

Health

- Medicaid recipients increased by more than 40,000 (37%) between FY 2018 and FY 2021, from 119,606 to 163,942 individuals.
- Almost 12,000 Fairfax County older adults (4% of the over 55 population) were uninsured in 2019.
- Over 87,000 Fairfax County residents have a disability, which includes people with hearing, vision, cognitive, ambulatory, self-care, and/or independent living disabilities.
- The Community Health Centers provided health care services to over 30,800 Fairfax County residents in 2020. The overwhelming majority of those served belong to vulnerable populations, such as the uninsured, racial or ethnic minority groups, non-native English speakers, and low-income residents.

In 2019, **over 307,000** County residents (nearly 27%) were age 55 and older.

In 2019, there were over 95,500 County residents (8.5%) without health insurance.

ATTACHMENT I

Draft 2023 Human Services Issue Paper – Items to be Reviewed for Updates/Revisions

FACT SHEET STATS TO BE REVIEWED BY CSB, DFS, HCD, HEALTH, NCS, AND COMMISSION FOR WOMEN

Mental and Behavioral Health

- The Northern Virginia Mental Health Institute (NVMHI), one of the smaller state hospitals despite the large population it serves, continues to experience periods of 100% capacity.
- Since 2016 more than 2,400 people in Fairfax County have been diverted from potential arrest due to the County's Diversion First program.
- In Fairfax County, there has been a 28% decrease in the behavioral health population with misdemeanor charges from 2015 to 2020.
- From 2015 to 2020, the number of inmates referred to Fairfax-Falls Church Community Services Board (CSB) jail-based services increased by 21%.

In FY 2020, **61%** of people receiving County services for mental illness, substance use disorder, or Developmental Disabilities had **incomes below $12,000.**

- The Fairfax County Police Department responded to nearly 10,000 mental health-related calls in calendar year 2020.
- In FY 2021, CSB conducted over 1,600 mental health evaluations related to emergency custody orders – a 312% increase from FY 2015.
- According to the most recent Fairfax County Youth Survey, 36% of students reported high levels of stress, 30% reported depressive symptoms, 14% reported thoughts of suicide, and 6% reported suicide attempts.[+]
- In FY 2021, over 20,000 individuals received Fairfax-Falls Church CSB mental health, substance use disorder, or DD services. Over 6,300 residents received CSB emergency services.
- Though Fairfax County was allocated 146 Developmental Disability (DD) Medicaid Waiver slots in FY 2022, 829 individuals remain on the County's Priority One waiting list, which is more than 25% of the total statewide waiting list.
- Nearly 2,700 of the over 14,000 individuals with DD on the statewide Medicaid waiver waiting list (as of September 2021) are served by the Fairfax-Falls Church CSB.
- From FY 2016 to FY 2021, the average monthly number of children seeking or receiving early intervention services for developmental delays grew by 3.3%, from 1,554 to over 1,605.

Substance Use Disorder

- The number of fatal overdoses set a new record high, with about 2,300 fatalities in calendar year 2020 – an increase of over 40 percent from 2019.
- In the Fairfax Health District (including Fairfax County and the cities of Fairfax and Falls Church), opioids are the number one cause of unnatural death, with 94 opioid deaths in 2020; all but seven of these fatalities were due to fentanyl.
- Hospitals in the Fairfax Health District reported a 35% increase in the number of emergency room visits for opioid overdoses (including heroin and non-heroin) in 2020 compared to 2019.
- The Youth Survey found that, within a month of the survey date, and without a doctor's order, approximately 800 students reported taking painkillers, and more than 1,000 reported taking other prescription drugs.[+]
- E-cigarettes have been the most used tobacco product among youth across the US since 2014.
- In 2020, more than 3.6 million American middle and high school students reported using e-cigarettes in the previous 30 days.

ATTACHMENT I

Draft 2023 Human Services Issue Paper – Items to be Reviewed for Updates/Revisions

FACT SHEET STATS TO BE REVIEWED BY CSB, DFS, HCD, HEALTH, NCS, AND COMMISSION FOR WOMEN

- The Youth Survey found that more students reported vaping than using any other substances, and lifetime prevalence rates were 13.2% of 8th graders, 26.2% of 10th graders, and 37.3% of 12th graders.[+]

Gang Involvement

- The Youth Survey found that approximately 590 students in the 8th, 10th, and 12th grades report being a gang member at some point in their life.[+]
- The average age of initial gang participation is 12.2 years old.[+]

English Proficiency

- 15% of County residents over age 5 do not speak English proficiently.
- 7% of households are "linguistically isolated," meaning the household includes no one over age 14 who speaks English proficiently.
- 40% of County residents over age 5 speak a language other than English at home.

Child Care

- Families in Fairfax County receiving child care subsidies have an annual median income of nearly $30,000, while the cost of full-time child care for a preschooler at a child care center can range from over $15,000 to over $21,000 per year (nearly $19,000 to over $24,500 per year for an infant). In comparison, the average cost of tuition and fees for a public college in Virginia is $13,860.
- In Fairfax County, state Virginia Preschool Initiative (VPI) funding provides less than half ($7,327) of the cost of VPI services to a child in a Fairfax County community-based early childhood program (approximately $18,200), which is insufficient to expand the program under current requirements.

Child Welfare

- In FY 2021, almost 1,200 families were served by County child abuse and neglect prevention programming.
- In FY 2021, Child Protective Services (CPS) conducted over 1,900 family assessments and investigations in response to valid referrals of child abuse and neglect, and almost 300 families were served in CPS ongoing services to keep children with their families.
- An average of 197 children were in foster care each month during FY 2021.

Nutrition

- The SNAP (food stamps) average monthly caseload increased nearly 13% between FY 2020 and FY 2021 (from approximately 20,400 families to 23,150 families) – average monthly caseloads have doubled from FY 2008 to FY 2021, from over 11,500 to 23,143.
- Meals provided to older adults and adults with disabilities through County programs continue to increase at a rapid pace – Home Delivered and Congregate meals increased by 13.8% from FY 2018 (512,881) to FY 2021 (583,743), but 8% of that increase occurred between FY 2020 (539,776) and FY 2021.

FACT SHEET STATS TO BE REVIEWED BY CSB, DFS, HCD, HEALTH, AND NCS

Domestic and Sexual Violence

- In FY 2021, the Fairfax County Domestic Violence Action Center (DVAC) served over 900 victims. There were 983 children (80% of whom were 12 years old or younger) living with victims served by the DVAC.
- Each month in Fairfax County, domestic violence (DV) hotlines receive over 126 calls on average, victims request 71 family abuse protective orders, and 12 families escape to an emergency DV shelter (FY 2021).
- In FY 2021, the Fairfax County Police Department responded to 3,010 DV calls, including 353 Lethality Assessment Program (LAP) calls. There were 127 arrests made due to strangulation (which is a significant predictor of future lethal violence).
- 171 families needing emergency shelter due to DV were placed in hotels in FY 2021 for reasons such as family size, geographical location, or bed shortage. 117 households were not housed because at the time of the call, they did not meet the criteria for imminent danger (no person in imminent danger is turned away).
- On the night of the 2021 Point in Time Count, there were 61 families in Fairfax County who were homeless due to DV.
- In FY 2021, there were 93 households (including 212 children) served in the four homeless shelters for families that reported a history of DV. In FY 2021, 44% of emergency DV shelter residents were children 12 years and younger.

+The 2019-2020 Fairfax County Youth Survey includes responses from 8th, 10th, and 12th grade students. (Note: The Youth Survey was not conducted during the 2020-2021 school year.)

Data is drawn from the US Census Bureau, US Bureau of Labor Statistics, MIT's Living Wage Calculator, VA Department of Health, VA Department of Behavioral Health and Developmental Services, UVA's Weldon Cooper Center for Public Service Demographics Research Group, and Fairfax County sources.

MEMO TO THE CPMT

July 29, 2022

Information Item I- 3: Update on Private Day Rate Setting

ISSUE: That implementation of rate setting for Private Day special education schools has been postponed to July 1, 2023.

BACKGROUND:

The Office of Children's Services selected a contractor, Public Consulting Group (PCG), to conduct a study of rates for Private Day programs, in compliance with the Appropriations Act in 2019. The study was inconclusive due to low participation by providers and was continued in 2021. Attached is the summary of their findings which recommended a nine-tier system of rates for these programs. The tiers are based on the teacher to student ratio and teacher aide to student ratio. Programs in Northern Virginia will have a geographic add-on to address higher costs in this region and separate "tiers" for coding in state reporting.

OCS held a training with PCG on June 17, 2022 to inform local government staff, schools and private providers about new requirements for LEDRS reporting to include these tiers. The expectation is that by August 1, 2022 the service name Special Education Day School will be replaced by 19 new codes, one for each tier (NOVA, other regions, and out of state). The state did clarify that out of state programs that already have rate setting will not be required to use the new tiers,or rate setting methodology. In addition, Private Day programs will be expected to complete data about each youth served by locality for submission to OCS for them to use for their fiscal analysis of the impact of rate setting. OCS expressed their intent to use the new service codes and this data to determine projected impact for implementation of the methodology in FY24.

Staff have not had sufficient opportunity to work with private day school providers. Next steps are working with our software vendor to update the system for reporting, finalize contracts with private day providers, and begin attempting to classify current placements into the tier system. Additional training will be offered on June 29th and consultation will be offered by PCG. Staff will provide CPMT with our projected fiscal impact and other implementation concerns.

ATTACHMENT: OCS Administrative Memo – Service Names for Private Day Programs: Cost Study of Private Day Special Education Programs

STAFF:
Janet Bessmer, CSA Director
Kelly Conn-Reda, FCPS

COMMONWEALTH of VIRGINIA

OFFICE OF CHILDREN'S SERVICES
Administering the Children's Services Act

Scott Reiner, M.S.
Executive Director

ADMINISTRATIVE MEMO #22-03

To: CPMT Chairs, CSA Coordinators, and Report Preparers
From: Preetha Agrawal, Information Technology Director
CC: Scott Reiner, Executive Director
Date: June 2, 2022

Subject: Service Names for Private Day Special Education – Fiscal Year 2023

As a result of the need to develop a fiscal impact analysis for the new standardized rate-setting model for private day special education (per the state budget language awaiting the Governor/s approval), there is a need to make changes to the LEDRS Service Names for this service.

Beginning with purchase orders for the 2022-2023 school year (any purchase orders for services beginning on or after August 1, 2022), the Service Name Private Day School (26) shall no longer be active/accepted. A new set of Service Names and Codes will be issued in conjunction with the upcoming training on the rate-setting process and all Purchase Orders for the new (2022-2023) school year need to be entered after the training is complete. The new coding is being disseminated to the various "front-end' software systems (e.g, Thomas Brothers) so they can add the new codes to their systems.

This issue will be discussed in detail at the upcoming training events so you are strongly encouraged to attend one of those sessions.

NOTE: Under the current budget language, the actual implementation of the new rate structure is delayed until July 1, 2023. You may, therefore, continue to establish your contracts with providers for the upcoming year as the rate-setting process will not be in effect until next year.

Please contact the OCS Office at 804-662-9815 or csa.office@csa.virginia.gov for additional information.

Thank you for your cooperation.

Office of Children's Services

Cost Study of Private Day Special Education Programs

Final Report

Report to the Governor and Chairmen of the House Appropriations and Senate Finance Committees pursuant to Item 293 (B) of Chapter 552 of the 2021 Appropriation Act

November 22, 2021

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Authority

This report has been prepared and submitted to fulfill the requirements of Item 293(B) of Chapter 552, the 2021 Appropriation Act. This provision requires the Office of Children's Services (OCS) to contract for the continuation of the study on the current rates paid by localities to special education private day programs licensed by the Virginia Department of Education.

Overview

The Office of Children's Services conducted the initial study on this topic as required by the Appropriation Act in 2019 through a competitive Request for Proposals to solicit a contractor to conduct the study. Public Consulting Group (PCG) was selected as the contractor. Due to an insufficient response rate by the private school providers, OCS was directed to continue the study in 2021. Additional requirements, incentives, and conditions were adopted for the 2021 continuation. OCS again contracted with PCG to continue the study. The remainder of this report reflects the work of PCG and OCS to meet the requirements of the project.

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Continuation of Study on Rates for Private Day Special Education Services

Commonwealth of Virginia

Office of Children's Services

November 2021

PUBLIC
CONSULTING GROUP

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EXECUTIVE SUMMARY

Public Consulting Group LLC (PCG) was contracted by the Commonwealth of Virginia Office of Children's Services (OCS) to continue the study of the current rates paid by localities to private day special education programs licensed by the Virginia Department of Education (DOE) and develop findings and recommendations based on the analysis for these rates. This executive summary condenses the report into the following components: themes and recommendations.

THEMES

The following major themes emerged during the study:

- Private day special education schools serve students with a mix of behavioral, emotional, physical, developmental, and educational needs.
- The number (and salaries) of teachers and teacher aides are the primary, although not exclusive, cost driver for program expenses.
- Services such as occupational and/or physical therapy, speech-language therapy, and psychological testing are billed almost exclusively outside of the daily rate and should remain that way.
- Costs are higher in northern Virginia than the rest of the State.
- The cost collection tools utilized in the previous PCG study (completed in 2019) were too burdensome; cost collection tools utilized by the 2020 Joint Legislative Audit and Review Commission (JLARC) study were less burdensome.
- Providers felt that a mix of actual revenue and expenses (FY19) and budgeted rates and staffing levels (FY21 and FY22) on the cost report tool would allow a more accurate picture, particularly in light of the COVID-19 pandemic.

With these themes in mind, PCG revised the cost collection tools, analyzed cost and program budget data, and developed the recommendations below.

RECOMMENDATIONS

Schools reported their FY21 rates along with the staffing levels associated with each rate. The majority (65%) reported having a program model with a ratio of one teacher to eight or higher students. For teacher aides (known by various titles in different programs), most (44%) reported having a model with one teacher aide to every four or more students in a classroom. The table below shows the number of programs reported by staffing ratio. The table does not indicate how many students are served at each level.

Program Staffing Matrix		Teacher Aide to Student Ratio		
		1:1	1:2 or 1:3	1:4 or more
Teacher to Student Ratio	1:3 or lower	1 (0.9%)	3 (2.5%)	3 (2.5%)
	1:4, 1:5, 1:6, 1:7	4 (3.4%)	10 (8.5%)	19 (16.1%)
	1:8 or higher	24 (20.3%)	24 (20.3%)	30 (25.4%)

PCG created nine (9) base rate models using three different teacher to student ratios, each with three different teacher aide to student ratios. These models allow for a range of programs to meet student needs and mirror the programs currently being utilized. A 23% salary add-on is proposed for programs in northern Virginia to account for a higher cost of living in those areas. The Northern Virginia (NOVA) geographic area was identified using the geographic area and pay band differential guidance issued by the Virginia Department of Human Resource Management for Northern Virginia. PCG recommends the rates in the following table based on the methodologies and calculations described in this report.

Model	Teacher to Student Ratio	Teacher Aide to Student Ratio	Base Rate	Northern Virginia (NOVA) Add-On*
1	1:3	1:1	$503.12	$96.95
2	1:3	1 :2 to 1: 3	$341.70	$62.83
3	1:3	1: 4+	$301.34	$54.30
4	1:4 to 1:7	1:1	$448.72	$85.39
5	1:4 to 1:7	1: 2 to 1:3	$287.29	$51.27
6	1:4 to 1:7	1:4+	$246.95	$42.74
7	1:8+	1:1	$418.11	$78.88
8	1:8+	1:2 to 1:3	$256.70	$44.76
9	1:8+	1:4+	$216.34	$36.23

*Northern Virginia (NOVA) geographic add-on (23% increase based on staff costs) was calculated for schools in the counties of: Fairfax, Arlington, Prince William, and Loudon and the cities of: Alexandria, Fairfax, Falls Church, Manassas, and Manassas Park

I. PROJECT GOALS

This project was authorized to continue the study of the current rates paid by localities to private day special education programs licensed by the Virginia Department of Education (DOE) and funded through the Children's Services Act (CSA) and to "... (i) provide definitions and clear delineation between all staff and positions used by private day schools and assessed in the study; (ii) define which staff positions can be included in the classroom staff ratio assessment; (iii) assess all costs associated with regulatory licensing; and (iv) require providers to report costs and distinguish between different locations." (2021 Virginia Appropriation Act, Chapter 552.Item 293. B.)

Specific goals included:

- Standardize the rate methodology while also meeting the needs of a diverse range of students.
- Account for geographic differences in cost.
- Create a transparent, replicable, and implementable methodology.

The project consisted of two phases:

Phase I consisted of:

- Determining priorities for OCS and other stakeholders.
- Designing cost collection tools and data collection methodology.

Phase II consisted of:

- Collecting and analyzing data.
- Developing the rate methodology and final report, including recommended rates for private day special education schools.

II. SUMMARIES OF STAKEHOLDER MEETINGS

PCG and OCS identified a voluntary and representative Provider Advisory Council (the Advisory Council) to meet monthly for the purpose of providing guidance and input to the project team throughout the rate setting study process.

Throughout the data collection process, PCG invited all private day school providers to participate in focus groups and held meetings with the Advisory Council, and other community partners, to discuss key issues to consider in the rate methodology. The table below lists all such meetings.

Meeting Date	Engagement Type	Summary
March 23, 2021	Advisory Council Kick Off	Introduced the project teams and collected initial feedback on prior rate study
April 15, 2021	Advisory Council Meeting	Reviewed model rate structure and cost collection tool
May 14, 2021	Advisory Council Meeting	Responded to cost collection tool feedback and timeline review
June 2, 2021	Data Collection Tool Training	All providers were invited to a training on how to complete and submit the cost collection tool
July 15, 2021	Advisory Council Meeting	Discussed cost collection tool submissions and introduced focus group topics
August 17, 2021	Focus Group	Collected input on elements of a program and costs
August 18, 2021	Focus Group	Collected input on program staffing
August 23, 2021	Focus Group	Collected input on rates of service
October 13, 2021	Advisory Council Meeting	Collected input on draft rate model structure
October 21, 2021	VAISEF Virtual Fall Conference & Membership Meeting	Reviewed draft proposed new model rate structure

Below is a summary of recurring themes gathered during stakeholder sessions.

CURRENT RATES: The current rates contain a variety of services, staffing arrangements, and programs offer varying numbers of student days per year. Staff is the most significant, but not the only cost driver. Services such as speech-language, occupational, and physical therapy are generally covered outside of the daily rate.

INDIVIDUAL STUDENT NEED: Schools must meet the needs of a diverse range of students and the overwhelming concern was that a standardized methodology would hinder the ability of schools to do that. Tiered rate options were discussed, and schools noted some concerns with implementing a tiered model equitably and being able to move children through tiers as needed.

COVID-19: Cost shifts in response to environmental factors, especially considering COVID-19 infrastructure requirements, improvements in technologies, curriculum development, and staffing issues/shortages.

GEOGRAPHIC ADJUSTMENTS: The cost of living is higher in northern Virginia than the rest of the state and this should be accounted for in the rates.

COST COLLECTION: The cost collection tools utilized in the previous PCG study were too burdensome; cost collection tools utilized by the recent Joint Legislative Audit and Review Commission (JLARC) study were less burdensome. Also, cost collection tools were not able to capture unmet needs that could not be addressed due to lack of funds.

III. MODIFICATIONS TO THE COST COLLECTION TOOL

A primary goal of this rate study process was to gather as much feedback and data from schools as possible. The project team prioritized the first few months of the project timeline developing a simplified cost collection tool to increase response rates. The PCG team incorporated feedback from the Advisory Council to tailor the data collection tool to the needs of this study and better align it with previously completed data collection reports (i.e., the JLARC report).

A full summary of modifications made to the data collection tools from the 2019 rate setting study can be found in Appendix A. Below are highlights.

- The detailed personnel roster data collection tool was eliminated entirely, instead utilizing one cost collection tool that required less detail.
- For ease of reporting, the format of the report was aligned with the JLARC study where possible, especially in the staffing questions.
- Schools were asked to complete a cost report for each location, to meet the legislative study requirements and so geographic differences in costs could be evaluated.
- Expenses were collected from FY19 (last full year prior to the COVID-19 disruptions).
- Additional sheets were added to the cost report to collect staffing rates, types of staff, number of students, and services included in the rates for each program's rates in FY21 and FY22.
- An additional comment section was added to capture issues unmet by the above modifications and information outside of the cost report.

IV. METHODOLOGY & FINDINGS

COST COLLECTION PROCESS

Public Consulting Group sent a letter to all DOE-licensed private day special education programs which included the expectations and plan for the rate setting effort. PCG provided all schools with the cost collection tool and instructions for how to provide their cost information on June 1, 2021. A virtual training session was held on June 2, 2021, to discuss how to complete the cost collection tool. Schools were "walked through" the instructions and the PCG team answered any questions about the data collection tool. The training was recorded, and the recording was provided to schools along with written instructions for how to complete the cost reports. Schools were able to ask questions to the PCG team by email anytime or by phone during designated office hours. Office hours were held twice each week throughout the cost collection period from Wednesday, June 2, 2021, through Friday, July 23, 2021.

Cost Collection Activities	Date(s):
Data Collection Tool **Distribution and Posting**	June 1, 2021
Data Collection Tool **Training**	June 2, 2021
Data Collection Tool **Return to PCG by email**	July 30, 2021

Each report underwent a quality assurance process upon submission. Reports were reviewed to ensure that the data provided for each field of the cost collection tool aligned with the instructions. Questions about specific cost information provided were sent back to the school contact to ensure that the cost collection tool captured the data in a uniform manner, allowing cost data to be analyzed across the different programs. Once all outstanding questions were answered and numerical discrepancies updated, the school's cost collection report was validated for use in the rate analysis.

COST REPORT ANALYSIS

PCG collected and validated cost report data from 64 (of 93 or 69%) licensed private day schools. Schools ranged in size from four students to 200 students (Table 1). Data were collected for three school years, FY19 (actual revenue and expenses), FY21 (budgeted costs) and FY22 (projected budgeted costs). However, all three years of data were not available and/or submitted for all 64 schools that submitted cost reports. Below shows a breakdown of the information obtained.

Table 1: Cost Report Data by Year

Submitted Cost Report	FY19 Revenue and Expenses	FY21 Budgets	FY22 Projected Budgets
64	47 (73%)	62 (97%)	36 (56%)

The cost report data was analyzed using the below methods:

Data Quality Analysis: Individual cost reports were reviewed, then combined. After combining all cost report data, a second layer of analysis was completed to identify outliers from the combined data. After consultation with OCS, the outliers were addressed for consistency measures.

Fiscal Years of Data: 97% of the submitted cost reports included budgeted costs and staffing for FY21 (note that FY22 budgeted costs were optional to submit). Because of the high response rate, FY21 data was used to identify common staffing patterns, services included in the daily rates, and for the fiscal impact analysis. FY19 expenses were used as the basis for costs in the rate models (with a cost adjustment factor for annualized "inflation" applied).

Personnel

The expenditure analysis revealed that teacher salaries accounted for 29% of school expenses and teacher aide salaries accounted for 23%, overall accounting for more than half of all expenses; pointing to teacher and teacher aide salaries being key cost drivers for the programs. Due to the impact that teacher and teacher aide salaries had on expenses, PCG analyzed the programmatic teacher and teacher aide structure of the reporting schools. Schools reported the teacher to student ratio and the teacher aide to student ratio for each of their existing daily rates. Each tier of daily rates reported for the FY21 school year was plotted in a matrix to identify the most common program structures. Programs were aggregated into groupings of staffing levels to increase the number of programs within each group (Table 2). One-to-one teacher aide to student ratios was retained for each teacher to student ratio to account for when an IEP dictates this staffing level. Most programs had a 1:8 or more teacher to student ratio (66.0%) compared to 1:3 teacher to student ratio (5.9%) and the combined 1:4- 1:7 teacher to student ratios (28.0%). Similarly, more programs reported having a 1:4 or more teacher aide to student staffing ratio (44.0%) compared to the lower ratios.

Table 2: Program Staffing Matrix		Teacher Aide to Student Ratio		
		1:1	1:2 or 1:3	1:4 or more
Teacher to Student Ratio	1:3 or Fewer	0.9%	2.5%	2.5%
	1:4, 1:5, 1:6, 1:7	3.4%	8.5%	16.1%
	1:8 or more	20.3%	20.3%	25.4%

Nine base models were developed using three different teacher to student ratios, each with three different teacher aide to student ratios. These models allow schools to provide intensive 1:1 services at a variety of teacher to student intensities and receive a higher rate to cover the additional costs of more intensive staffing configurations. Base rate models include 1:3 teacher to student, 1:4 - 1:7 teacher to student, and 1:8 or higher teacher to student ratios (Table 3). Teacher aide to student ratios were broken down as 1;1, 1:2 or 1:3, and 1:4 or more. Since models covered more than one teacher to student and teacher aide to student ratio, staffing costs used to create the daily rates were calculated using 3, 5, and 8 for teachers and 1, 2.5, and 4 for teacher aides (average for the model).

Table 3: Staffing Model Ratios

Model	Teacher Ratio	Teacher Aide Ratio	Teacher to Student Ratio used for Cost Calculations	Teacher Aide to Student Ratio used for Cost Calculations
1	1:3	1:1	3	1
2	1:3	1:2 to 1:3	3	2.5
3	1:3	1:4+	3	4
4	1:4 to 1:7	1:1	5	1
5	1:4 to 1:7	1:2 to 1:3	5	2.5
6	1:4 to 1:7	1:4+	5	4
7	1:8+	1:1	8	1
8	1:8+	1:2 to 1:3	8	2.5
9	1:8+	1:4+	8	4

Table 4: Staff to Student Ratios (Other Personnel)

Program Personnel Salaries	FTE to Student Ratio	FTE per student
Administrators	1: 50	0.020
Other Direct Student Support Staff (Bachelors)	1: 50	0.020
Other Direct Student Support Staff (Masters)	1: 25	0.040
Medical Staff	1: 25	0.040
Trade Staff	1: 60	0.017

Other staff included in the rate model are school administrators, other direct student support staff (with and without a master's degree), medical staff, and trade staff. These positions were found to be tied to student capacity at a school and did not need to be altered based on the intensity of the model. Therefore, staffing ratios and costs for these positions were the same across all models. Schools were allocated one FTE per 50 students for school administrators and direct student support staff with a bachelor's degree, additional staff was allocated for direct student support staff with a master's degree and medical staff one FTE per 25 students, and trade staff were calculated at one FTE per 60 students (Table 4). To calculate the per student per day cost, the FTE per student was calculated for each position.

Based on feedback from the focus groups, schools consider different numbers of annual work hours to be defined as full-time. To standardize staffing costs across programs, PCG calculated per hour pay for all staff positions using the total expense per position, the number of full-time equivalents reported for each position and the number of hours worked using the FY19 school year data. All hourly salaries that were below the 2022 Virginia minimum wage were increased to $11 an hour. Outlier costs were identified for each staff position by flagging any hourly wage that was two or more

standard deviations from the mean within each staffing type. Outliers were removed from the analysis and accounted for no more than three responses for any specific staff position. PCG compiled the hourly wage data (after the outliers were removed and salaries below minimum wage were increased), and calculated the average hourly pay for each reported position: school administrators, teachers, teacher aides, other direct student support staff with a bachelor's degree, other direct student support staff with a master's degree, medical staff, and trade staff. Since an add-on cost was developed for schools located in the Northern Virginia region and in the focus groups stakeholders voiced that this region had higher salary costs, staff salaries from those schools identified as located in Northern Virginia were removed from the calculation. The salary differential for Northern Virginia will be captured in a regional add-on cost that Northern Virginia schools can apply.

Administrators were the highest paid positions making on average $32.48 per hour, while teacher aides had the lowest average wages, $16.75 per hour (Table 5). Teachers and other direct student support staff with a master's degree made similar amounts per hour ($25.55 and $27.69, respectively). Based on the cost reports, teacher salaries were built into the rate calculations at an average annual salary of $53,144. The Bureau of Labor Statistics reports the national mean salary for special education teachers ranged from $48,530 to $52,680 depending on the grade level in 2019. The salary proposed in the models is slightly higher than this. Looking specifically at Virginia, the Department of Education reported in 2019 the average wage for special education teachers across the state was $57,146, which is slightly higher than the base salary proposed in the models. However, when computing the weighted average of the salaries for the new models using the additional salary increase for schools in Northern Virginia, the weighted average wage is $56,094.41, which is very close to the DOE-reported average.

Table 5: Hourly Wage by Position

Program Personnel Salaries	Hourly Wage
Administrators	$34.48
Teachers	$25.55
Teacher Aides	$16.75
Other Direct Student Support (Bachelors)	$21.22
Other Direct Student Support (Masters)	$27.69
Medical Staff	$21.92
Trade Staff	$19.16

A staffing relief factor provides schools with additional funds to cover costs incurred when teachers and teacher aides are on vacation or sick leave. These monies can be used to pay for substitute teachers or aides. In consultation with OCS, a relief factor of 3.85% was calculated based on 80 hours per year of time-off per teacher and teacher aide FTE. The relief factor was applied to the salary costs for these two positions. Using the nine base models that were created, the number of relief FTEs were calculated to determine the cost associated with the relief factor. Teacher relief FTEs ranged from 0.770 to 0.289, while aides ranged from 2.31 to 0.578 (Table 6).

Table 6: Teacher and Teacher Aide Relief FTEs for Base Rate Models

Model	Teacher to Student Ratio	Teacher Aide to Student Ratio	Number of Relief Teacher FTE's	Number of Relief Teacher Aide FTE's
1	1:3	1:1	0.770	2.31
2	1:3	1 :2 to 1: 3	0.770	0.924
3	1:3	1: 4+	0.770	0.578
4	1:4 to 1:7	1:1	0.462	2.31
5	1:4 to 1:7	1: 2 to 1:3	0.462	0.924
6	1:4 to 1:7	1:4+	0.462	0.578
7	1:8+	1:1	0.289	2.31
8	1:8+	1:2 to 1:3	0.289	0.924
9	1:8+	1:4+	0.289	0.578

Information about fringe benefits was collected in two areas in the cost report. Programs were asked to provide their required fringe benefit costs as well as the costs of any optional benefits they provide to staff. These two types of benefits were added together for each program and the average was taken. The results showed a lower percentage of fringe benefits to salary expenses than were expected, 16.5% of the personnel costs. Therefore, a more robust 23% was applied for fringe benefits based on knowledge PCG has from similar rate studies, most tax and fringe rates used in other PCG methodologies range between 20-30%.

Operating Expenses

Operating costs were similarly analyzed for outliers. Expenses were calculated for each item (i.e., travel, vehicles, occupancy/facility costs, student technology, classroom supplies, program equipment, insurance, translation/interpretation services, and other costs) as per student per day costs. The total expenditure for each item was divided by the total number of student days served. Teacher training was the exception, which was calculated as the cost per teacher and teacher aide FTE. The average cost for each item across all programs was calculated and outliers were identified to be those costs that were two standard deviations above or below the mean. No more than four outlier responses were removed from any cost category.

Teacher training expenses averaged to be $754.36 per teacher and teacher aide FTE. Since training expenses are tied to staffing levels, these expenses are different across all nine models in the per student per day cost. The most expensive cost is $5.59 per student per day, while the least expensive is only $1.57 per student per day and corresponds to the intensity of the program (Table 7). All other per student per day operating costs remain the same across all models.

Table 7: Training Costs per Student for each Base Model

Model	Teacher to Student Ratio	Teacher Aide to Student Ratio	Cost Per Student Per Day
1	1:3	1:1	$5.59
2	1:3	1 :2 to 1: 3	$3.07
3	1:3	1: 4+	$2.44
4	1:4 to 1:7	1:1	$5.03
5	1:4 to 1:7	1: 2 to 1:3	$2.51
6	1:4 to 1:7	1:4+	$1.89
7	1:8+	1:1	$4.71
8	1:8+	1:2 to 1:3	$2.20
9	1:8+	1:4+	$1.57

Among the other operating costs, the most expensive per student per day cost was associated with occupancy or facility payments, $24.51. The remaining costs were each under $5.50 per student per day (Table 8).

Table 8: Operating Expenses per Student per Day

Operating Expenses	Per Student Per Day Cost
Travel Expenses (i.e. mileage)	$ 0.67
Vehicle Expenses	$ 1.22
Occupancy/Facility (mortgage, rent, etc.)	$24.51
Student Technology	$ 1.19
Classroom Supplies	$ 3.61
Program Equipment	$ 1.94
Insurance	$ 2.54
Translation/Interpretation Services	$ 2.25
Other Costs	$ 5.16

Adjustment Factors

Programmatic costs were collected from schools to reflect the expenses incurred during the FY19 school year. Since budget models were created to reflect costs in 2022, a cost adjustment factor was calculated. The cost adjustment factor (CAF) was determined using the most recent Consumer Price Index (CPI) data published for Virginia and the surrounding area by the U.S. Bureau of Labor Statistics. CPI data for all items was used for the CAF data. The percent difference in the costs in 2019 compared to 2022 was calculated to be about 6.85%. Therefore, an additional 7% of all budget costs was added into the daily rates for the cost adjustments that occurred between 2019 - 2022.

Focus group responses and Advisory Council members indicated that staff costs were not uniform across the state of Virginia. This differentiation is also recognized in the State pay band differential. Therefore, PCG identified the region in Northern Virginia in accordance with the State of Virginia pay differential. The Northern Virginia region includes the counties of Fairfax, Arlington, Prince William, and Loudon, and the cities of Alexandria, Fairfax, Falls Church, Manassas, and Manassas Park. The average staff salary for each position was calculated for the Northern Virginia schools and for the schools in the rest of the state. The percent difference was identified for each position. An average of the percent differences was taken to identify a 23% salary add-on for schools located in the Northern Virginia region. The calculated geographic increase was compared to the geographic pay band differential used by the Virginia Department of Human Resource Management for Northern Virginia compared to the rest of the state. The average wage differential across all pay bands between Northern Virginia and the rest of the state was found to be 24%, which was almost identical to the difference calculated using program cost data. To remain in line with the other model measures, it was decided to use the differential calculated from the program costs. The 23% salary add on was applied to each of the models to create nine different geographic add-ons each tied to a corresponding base rate (Table 9). Models that are more staff intensive receive a higher add on cost.

Table 9: Northern Virginia (NOVA) Add-On to Base Models

Model	Teacher Ratio	Teacher Aide Ratio	Northern Virginia (NOVA) Add On
1	1:3	1:1	$96.95
2	1:3	1 :2 to 1: 3	$62.83
3	1:3	1: 4+	$54.30
4	1:4 to 1:7	1:1	$85.39
5	1:4 to 1:7	1: 2 to 1:3	$51.27
6	1:4 to 1:7	1:4+	$42.74
7	1:8+	1:1	$78.88
8	1:8+	1:2 to 1:3	$44.76
9	1:8+	1:4+	$36.23

Services Included in the Rates

Programs were asked to indicate which services were included in each of their daily rates. Using the FY21 school year information, schools most often included IEP case management and counseling/behavioral therapy services in their daily rates (Table 10). Very few programs included services such as speech and occupational therapy or physical therapy in their daily rates. About a quarter of the schools include nurses; many included therapeutic services, and Career and Technical Education (CTE).

Table 10: Positions Included in Program Daily Rates

Position	Percent of Daily Rates with the Service Included
IEP Case Management	85%
Career & Technical Education / Vocational	60%
Counseling / Social Work / Psychotherapy	45%
Intensive Behavior Therapy	45%
ABA Therapy	43%
One-to-One Classroom Aide	41%
Other	35%
School Nursing	24%
One-to-One (Non-classroom Aide)	6%
Occupational and/or Physical Therapy	3%
Speech-Language	3%
Psychological Testing	2%
Extended School Day (ESD)	2%

Since speech-language services, occupational and/or physical therapy, and psychological testing were not generally assumed in the staffing models, it is expected that these costs are (and will continue to) be billed outside of the daily rate. Other services are assumed to be covered in the proposed rates, since their costs were reflected in the cost reports.

RATE METHODOLOGY

Table 12 below shows an example of the overall rate methodology utilized. The Table shows a draft budget for a school with 60 students with a 1:8 teacher to student and 1:2 or 1:3 teacher aide to student classroom.

Table 12: Example Budget
60 Students in a 1:8 Teacher to Student and 1:2 Teacher Aide to Student Classroom

Program Personnel Salaries	Hourly Wage	FTE	Full Time Hours	Expense
Administrators	$34.48	1.20	2080	$86,062.08
Teachers	$25.55	7.50	2080	$398,580.00
Teacher Aids	$16.75	24.00	2080	$836,160.00
Other Direct Student Report Staff (Bachelors)	$21.22	1.20	2080	$52,965.12
Other Direct Student Report Staff (Masters)	$27.69	2.40	2080	$138,228.48
Medical Staff	$21.92	2.40	2080	$109,424.64
Trade Staff	$19.16	1.00	2080	$39,852.80
Teacher Relief	$25.55	0.29	2080	$15,345.33
Teacher Aide Relief	$16.75	0.92	2080	$32,192.16

Tax and Fringe Benefits	Percent of Staff Salary	Expense
	23%	$393,026.44

Other Operating Expenses	Per Student Per Day	Teacher and Aide FTEs	Per Teacher Cost	Expense
Training Expenses for Teachers and Aides	$2.20	31.50	$754.36	$23,762.34
Travel Expenses (i.e., mileage)	$0.67	N/A	N/A	$7,236.00
Vehicle Expenses	$1.22	N/A	N/A	$13,176.00
Occupancy / Facility (mortgage, rent, etc.)	$24.51	N/A	N/A	$264,708.00
Student Technology	$1.19	N/A	N/A	$12,852.00
Classroom Supplies	$3.61	N/A	N/A	$38,988.00
Program Equipment	$1.94	N/A	N/A	$20,952.00
Insurance	$2.54	N/A	N/A	$27,432.00
Translation/Interpretation Services	$2.25	N/A	N/A	$24,300.00
Other Costs	$5.16	N/A	N/A	$55,728.00

Cost Adjustment Factor (CAF)	$181,367.83

Budget Section	Expense Total
Program Salaries	$1,708,810.61
Tax and Fringe Benefits	$393,026.44
Total Program Operating Expenses	$489,134.34
Cost Adjustment Factor	$181,367.83

Grand Total	$2,772,339.22

Total Daily Rate per Student	$256.70

Using the same methodology as above, the remaining daily rates were calculated to capture varying levels of instructional staffing. Across all rates, the variable costs were associated with the number of teacher and teacher aides. This variance impacted the number of FTEs for those positions resulting in differences in costs associated with teacher and teacher aide salary, relief, and training expenses. While the CAF was applied universally at 7%, the dollar amount that it added to each daily rate varied based on the staffing costs (salary, fringe benefits, and training) and was driven by the teacher and teacher aide FTEs. This resulted in nine base rates that range from $503.12 to $216.34, prior to application of a Northern Virginia (NOVA) geographic add-on (Table 13).

Table 13: Model Base Rates and Geography Add On Rates

Model	Teacher Ratio	Teacher Aide Ratio	Base Rate	Northern Virginia (NOVA) Add On*
1	1:3	1:1	$503.12	$96.95
2	1:3	1 :2 to 1: 3	$341.70	$62.83
3	1:3	1: 4+	$301.34	$54.30
4	1:4 to 1:7	1:1	$448.72	$85.39
5	1:4 to 1:7	1: 2 to 1:3	$287.29	$51.27
6	1:4 to 1:7	1:4+	$246.95	$42.74
7	1:8+	1:1	$418.11	$78.88
8	1:8+	1:2 to 1:3	$256.70	$44.76
9	1:8+	1:4+	$216.34	$36.23
*Northern Virginia (NOVA) add on (23% increase based on staff costs) was calculated for schools in the counties of Fairfax, Arlington, Prince William and Loudon and the cities of Alexandria, Fairfax, Falls Church, Manassas, and Manassas Park				

V. RECOMMENDATIONS

RATE RECOMMENDATIONS

PCG recommends the following daily rates for private day special education schools in VA.

Model	Teacher to Student Ratio	Teacher Aide to Student Ratio	Base Rate	Northern Virginia (NOVA) Add On*
1	1:3	1:1	$503.12	$96.95
2	1:3	1 :2 to 1: 3	$341.70	$62.83
3	1:3	1: 4+	$301.34	$54.30
4	1:4 to 1:7	1:1	$448.72	$85.39
5	1:4 to 1:7	1: 2 to 1:3	$287.29	$51.27
6	1:4 to 1:7	1:4+	$246.95	$42.74
7	1:8+	1:1	$418.11	$78.88
8	1:8+	1:2 to 1:3	$256.70	$44.76
9	1:8+	1:4+	$216.34	$36.23
*Northern Virginia (NOVA) add on (23% increase based on staff costs) was calculated for schools in the counties of Fairfax, Arlington, Prince William and Loudon and the cities of Alexandria, Fairfax, Falls Church, Manassas, and Manassas Park				

PCG makes these recommendations based on the preceding sections and reasons detailed below.

- ***Rate Study Results:*** The models are based on a consistent, objective, and reasonable methodology that uses school data to determine the actual cost of services and are driven by staffing ratios.
- ***Stakeholder Feedback:*** While it was not always possible for stakeholders to agree on every element of the model budgets or the rates themselves, these rates were developed with significant stakeholder feedback both from this cost study process and the previous VA OCS rate study engagement.
- ***Alignment with Program Goals:*** The recommended rates align with program goals, realistically reflect actual provider staffing levels and expenses, are more transparent, and allow for program changes and future updates to the rates as the programs evolve.

ADDITIONAL RECOMMENDATIONS

1. **Annual Cost Adjustment:**

   Rates should be updated to account for inflation on an annual basis. The rates should also be updated to account for any new statutory mandates, such as minimum wage increases.

2. **Implementation Standards and Monitoring**

   PCG recommends that VA OCS work with schools and local CSA offices to develop an implementation plan and approach. The application of the rate payments will need to be consistent with student's needs and growth. The bullets below describe important factors for VA OCS to consider during the implementation of the new rates.

- **Application of the new Rates:** Guidance needs to be developed for schools and CSA programs regarding how to select the appropriate rate to bill, how and when rates should be adjusted, and how extraordinary circumstances will be addressed.

- **Periodic Cost Collection**: Periodic cost collection, approximately every three to five years, would allow VA OCS to better understand and monitor the adequacy of the rates. This would allow OCS, local CSA programs, and other interested parties (e.g., legislative budget Committee members and staff, the Department of Planning and Budget) to monitor provider expenditures and staffing levels relative to contractual and staffing ratio requirements.

3. **Stakeholder Engagement**

   PCG recommends VA OCS continue to engage with the Advisory Committee assembled during this process through the implementation and monitoring of the established rates. The group of private school stakeholders provided critical feedback which directly impacted the final recommended rates.

4. **Extended School Year:** The recommended daily rates are calculated based on a 180-day calendar. If a school plans to operate an extended school year, VA OCS will need to determine if the daily rate may remain the same or change during the extended school year period. This determination should be based on whether the same services or a lower level of services are being provided. If a lower level of service offerings are provided, then a reduced rate should be determined.

VI. FISCAL IMPACT

The overall average impact of implementing the rates proposed in this study would result in an approximate 4% increase from the reported FY21 rates using a weighted average assumption. It is important to note, since it is not possible to determine how many students would fall into each model under the proposed rate structure, that a specific overall fiscal impact is undetermined at this time.

PCG estimated the fiscal impact of the proposed rate structure by looking at the reported FY21 daily rates for each program and comparing those to the average proposed new rate, using a weighted average based on the number of student days served in FY19. In addition to comparing the budget rates for FY21, PCG also mapped the teacher and teacher aide ratios for each tier to the new model rates. Below are four examples of schools that had varying daily rates in FY21. *Note: All FY21 daily rates are examples and do not represent any actual school.* In applying this method, if schools had two different daily rates in FY21 that mapped to the same new daily rate (School Example 2 and 3), PCG kept the tiers separate when calculating the school average daily rate to account for the likelihood there would be more students within those rates.

School 1 Example	New Rates	FY21 Example Daily Rate	Percentage of Program Allocated
1:3 Teacher / 1:2 Teacher Aide	$341.70	$328.17	33.3%
1:8 Teacher / 1:4 Teacher Aide	$216.34	$197.25	33.3%
1:4 Teacher / 1:1 Teacher Aide	$448.72	$427.48	33.3%
School Average Rate	$335.59	$317.63	

School 2 Example	New Rates	FY21 Example Daily Rate	Percentage of Program Allocated
1:3 Teacher / 1:2 Teacher Aide	$341.70	$320.54	33.3%
1:7 Teacher / 1:4 Teacher Aide	$246.95	$225.19	33.3%
1:4 Teacher / 1:5 Teacher Aide	$246.95	$246.46	33.3%
School Average Rate	$278.53	$264.06	

School 3 Example	New Rates	FY21 Example Daily Rate	Percentage of Program Allocated
1:7 Teacher / 1:4 Teacher Aide	$246.95	$219.67	50.0%
1:4 Teacher / 1:5 Teacher Aide	$246.95	$220.41	50.0%
School Average Rate	$246.95	$220.04	

School 4 Example	New Rates	FY21 Example Daily Rate	Percentage of Program Allocated
1:3 Teacher / 1:2 Teacher Aide	$341.70	$317.15	100.0%
School Average Rate	$341.70	$317.15	

PCG used the average school daily rates from FY21 and the average new rates to calculate a weighted average daily rate for the year. Using this method, it is important to note that the average daily rate accounted for larger schools serving more students and ultimately representing a larger percentage of the annual costs.

PCG used the number of FY19 student days served from the cost reports to calculate a percentage of annual school days that each school contributed *(Note: This information was not available for FY21)*. For example, School 1 has 16,075 school days served accounting for 43% of all school days served in FY19. School 1 drives more of the annual costs than School 4 which only contributes 6% of the daily rate payments each year. PCG multiplied the weighted percent of student days by the average school daily rate to find the school cost it contributes to the average annual daily rate. The contribution costs were

added across all four example schools to find the average annual daily rate. PCG applied the same methodology to compare with the new daily rates.

School Examples	Total Annual Student Days Served by Program	Weighted Percent of Total Student Days Served by Program *(Annual Student Days Served/Total Annual Student Days Served for All Program Schools)*	Contribution to the Average Annual Average Daily Rate *(Average Program New Rate x Weighted Percentage of Student Days Served by Program)*	Averages of FY21 Example School Rates *(Average Program FY21 School Example Rate x Weighted Percentage of Student Days Served by Program)*
School 1 Example	16,075	43%	$145.07	$137.31
School 2 Example	8,657	23%	$64.85	$61.48
School 3 Example	10,338	28%	$68.66	$61.17
School 4 Example	2,115	6%	$19.44	$18.04
Total for All Programs	37,185	100%	$298.01	$278.00

PCG found that the estimated weighted average annual daily rate for FY21 was $278.00 across all programs, and for the new model average, which included the Northern Virginia (NOVA) geographic 23% rate differential, was $298.01, an increase of 3.96% overall. These calculations assume that schools have equal numbers of students in each daily rate and therefore are only estimates of the impact of the new rates.

VII. ACKNOWLEDGEMENTS

Public Consulting Group would like to thank the many individuals and agencies that contributed to this report. PCG greatly appreciates the time and effort invested towards this project. Also, thanks to the Advisory Council, that provided invaluable input, as well as all the schools that participated in submitting data.

Rate Study Advisory Council	
Member & Title	**Organization**
Beth Ackerman, CEO	Rivermont Schools
Kyle Averill, Director & Principal	The Kellar School
William Elwood	VAISEF
Rich Von Gersdorff, Vice President of Operations & CFO	Youth for Tomorrow
Ed Gillaspie, Director of Finance & Administration	Virginia Institute of Autism
Vanessa Lane	Grafton
Chuck Longerbeam, Education Coordinator	Elk Hill
Lori Perez	Youth for Tomorrow
Robyn Puryear, Vice President of Educational Services	KEYS Academy
Beth Putnam, Director of Education	The Hughes Educational Center
Nancy Toscano, COO	Charterhouse School
Terri Webber, Director of Education	Minnick Schools

VIII. APPENDIX A. MODIFICATIONS TO THE COST COLLECTION TOOL

An overview of the modifications to the cost collection tool from the 2019 study are listed below.

- PCG simplified the cost collection tool from two surveys to one. The level of detail requested was also decreased to allow schools to provide their information in a less granular level.
- The format of the report was aligned with the JLARC study, especially in the staffing questions, so schools could utilize their previous reporting materials.
- Schools were asked to report separately on individual locations and/or programs. For example, if a school operates four different program locations, they were asked to submit four individual cost reports.
- The cost report asked for more information about factors associated with school and cost differentiators:
  - Staffing, including which kind of staff.
  - How many students.
  - Program model assumptions built into budget.
- The staffing questions were streamlined into an array of staff categories, instead of asking schools to list each program staff. The following staffing categories below were combined into one line-item:
  - Counseling / Social Work / Psychotherapy
  - Occupational Therapy (OT) / Physical Therapy (PT)
- All expenses, school and indirect data was collected from FY19 (full year prior to COVID – not including virtual rates).
  - A line for student technology was added to school expenses.
- Additional category questions about school's Daily Rates were added:
  - Based on current year's budget expenditures.
  - Asked for a percentage of students receiving level or service.
  - Provided option for 7/1/21 – 6/30/22 but still requiring 7/1/20 – 6/30/21.
- Added question to the FY22 tab: "Are you budgeting for anything in FY22 related to the COVID-19 pandemic?" which included an open textbox.
- Added question: "Are there any expenses anticipated that are above and beyond what they've included in this cost report? For example, capital improvement costs."

IX. APPENDIX B. BASE RATE MODEL BUDGETS

PCG used 60 students as the basis for calculation of the nine base model example budgets. The daily rate at the end of each model is the per student per day cost and will be the same regardless of the number of students in the models.

1:3 TEACHER, 1:1 TEACHER AIDE BUDGET

Program Personnel Salaries	Hourly Wage	FTE	Full Time Hours	Expense
Administrators	$34.48	1.20	2080	$86,062.08
Teachers	$25.55	20.00	2080	$1,062,880.00
Teacher Aides	$16.75	60.00	2080	$2,090.400.00
Other Direct Student Report Staff (Bachelors)	$21.22	1.20	2080	$52,965.12
Other Direct Student Report Staff (Masters)	$27.69	2.40	2080	$138,228.48
Medical Staff	$21.92	2.40	2080	$109,424.64
Trade Staff	$19.16	1.00	2080	$39,852.80
Teacher Relief	$25.55	0.77	2080	$40,920.88
Teacher Aide Relief	$16.75	2.31	2080	$80,480.40

Tax and Fringe	Percent of Staff Salary	Expense
	23%	$851,279.31

Other Operating Expenses	Per Student Per Day	Teacher and Aide FTEs	Per Teacher Cost	Expense
Training Expenses for Teachers and Aides	$5.59	80.00	$754.36	$60,348.80
Travel Expenses (i.e. mileage)	$0.67	N/A	N/A	$7,236.00
Vehicle Expenses	$1.22	N/A	N/A	$13,176.00
Occupancy/Facility (mortgage, rent, etc.)	$24.51	N/A	N/A	$264,708.00
Student Technology	$1.19	N/A	N/A	$12,852.00
Classroom Supplies	$3.61	N/A	N/A	$38,988.00
Program Equipment	$1.94	N/A	N/A	$20,952.00
Insurance	$2.54	N/A	N/A	$27,432.00
Translation/Interpretation Services	$2.25	N/A	N/A	$24,300.00
Other Costs	$5.16	N/A	N/A	$55,728.00

Cost Adjustment Factor (CAF)	$355,476.64

Budget Section	Expense Total
Program Salaries	$3,701,214.40
Tax and Fringe Benefits	$851,279.31
Total Program Operating Expenses	$525,744.00
Cost Adjustment Factor	$355,476.64

Grand Total	$5,433,714.35

Total Daily Rate per Student	$503.12

1:3 TEACHER, 1:2 OR 1:3 TEACHER AIDE BUDGET

Program Personnel Salaries	Hourly Wage	FTE	Full Time Hours	Expense
Administrators	$34.48	1.20	2080	$86,062.08
Teachers	$25.55	20.00	2080	$1,062,880.00
Teacher Aides	$16.75	24.00	2080	$836,160.00
Other Direct Student Report Staff (Bachelors)	$21.22	1.20	2080	$52,965.12
Other Direct Student Report Staff (Masters)	$27.69	2.40	2080	$138,228.48
Medical Staff	$21.92	2.40	2080	$109,424.64
Trade Staff	$19.16	1.00	2080	$39,852.80
Teacher Relief	$25.55	0.77	2080	$40,920.88
Teacher Aide Relief	$16.75	0.924	2080	$32,192.16

Tax and Fringe	Percent of Staff Salary	Expense
	23%	$551,697.82

Other Operating Expenses	Per Student Per Day	Teacher and Aide FTEs	Per Teacher Cost	Expense
Training Expenses for Teachers and Aides	$3.07	44.00	$754.36	$33,191.84
Travel Expenses (i.e. mileage)	$0.67	N/A	N/A	$7,236.00
Vehicle Expenses	$1.22	N/A	N/A	$13,176.00
Occupancy/Facility (mortgage, rent, etc.)	$24.51	N/A	N/A	$264,708.00
Student Technology	$1.19	N/A	N/A	$12,852.00
Classroom Supplies	$3.61	N/A	N/A	$38,988.00
Program Equipment	$1.94	N/A	N/A	$20,952.00
Insurance	$2.54	N/A	N/A	$27,432.00
Translation/Interpretation Services	$2.25	N/A	N/A	$24,300.00
Other Costs	$5.16	N/A	N/A	$55,728.00

Cost Adjustment Factor (CAF)	$241,423.84

Budget Section	Expense Total
Program Salaries	$2,398,686.16
Tax and Fringe Benefits	$551,697.82
Total Program Operating Expenses	$498,528.00
Cost Adjustment Factor	$241,423.84

Grand Total	$3,690,335.82

Total Daily Rate per Student	$341.70

1:3 TEACHER, 1:4 OR MORE TEACHER AIDE BUDGET

Program Personnel Salaries	Hourly Wage	FTE	Full Time Hours	Expense
Administrators	$34.48	1.20	2080	$86,062.08
Teachers	$25.55	20.00	2080	$1,062,880.00
Teacher Aides	$16.75	15.00	2080	$522,600.00
Other Direct Student Report Staff (Bachelors)	$21.22	1.20	2080	$52,965.12
Other Direct Student Report Staff (Masters)	$27.69	2.40	2080	$138,228.48
Medical Staff	$21.92	2.40	2080	$109,424.64
Trade Staff	$19.16	1.00	2080	$39,852.80
Teacher Relief	$25.55	0.77	2080	$40,920.88
Teacher Aide Relief	$16.75	0.5775	2080	$20,120.10

Tax and Fringe	Percent of Staff Salary	Expense
	23%	$476,802.44

Other Operating Expenses	Per Student Per Day	Teacher and Aide FTEs	Per Teacher Cost	Expense
Training Expenses for Teachers and Aides	$2.44	35.00	$754.36	$26,402.60
Travel Expenses (i.e. mileage)	$0.67	N/A	N/A	$7,236.00
Vehicle Expenses	$1.22	N/A	N/A	$13,176.00
Occupancy/Facility (mortgage, rent, etc.)	$24.51	N/A	N/A	$264,708.00
Student Technology	$1.19	N/A	N/A	$12,852.00
Classroom Supplies	$3.61	N/A	N/A	$38,988.00
Program Equipment	$1.94	N/A	N/A	$20,952.00
Insurance	$2.54	N/A	N/A	$27,432.00
Translation/Interpretation Services	$2.25	N/A	N/A	$24,300.00
Other Costs	$5.16	N/A	N/A	$55,728.00

Cost Adjustment Factor (CAF)	$212,910.64

Budget Section	Expense Total
Program Salaries	$2,073,054.10
Tax and Fringe Benefits	$476,802.44
Total Program Operating Expenses	$491,724.00
Cost Adjustment Factor	$212,910.64

Grand Total	$3,254,491.18

~~Total~~ Daily Rate per Student	$301.34

1:4 TO 1:7 TEACHER, 1:1 TEACHER AIDE BUDGET

Program Personnel Salaries	Hourly Wage	FTE	Full Time Hours	Expense
Administrators	$34.48	1.20	2080	$86,062.08
Teachers	$25.55	12.00	2080	$637,728.00
Teacher Aides	$16.75	60.00	2080	$2,090,400.00
Other Direct Student Report Staff (Bachelors)	$21.22	1.20	2080	$52,965.12
Other Direct Student Report Staff (Masters)	$27.69	2.40	2080	$138,228.48
Medical Staff	$21.92	2.40	2080	$109,424.64
Trade Staff	$19.16	1.00	2080	$39,852.80
Teacher Relief	$25.55	0.462	2080	$24,552.53
Teacher Aide Relief	$16.75	2.31	2080	$80,480.40

Tax and Fringe	Percent of Staff Salary	Expense
	23%	$749,729.63

Other Operating Expenses	Per Student Per Day	Teacher and Aide FTEs	Per Teacher Cost	Expense
Training Expenses for Teachers and Aides	$5.03	72.00	$754.36	$54,313.92
Travel Expenses (i.e. mileage)	$0.67	N/A	N/A	$7,236.00
Vehicle Expenses	$1.22	N/A	N/A	$13,176.00
Occupancy/Facility (mortgage, rent, etc.)	$24.51	N/A	N/A	$264,708.00
Student Technology	$1.19	N/A	N/A	$12,852.00
Classroom Supplies	$3.61	N/A	N/A	$38,988.00
Program Equipment	$1.94	N/A	N/A	$20,952.00
Insurance	$2.54	N/A	N/A	$27,432.00
Translation/Interpretation Services	$2.25	N/A	N/A	$24,300.00
Other Costs	$5.16	N/A	N/A	$55,728.00

Cost Adjustment Factor (CAF)	$317,038.38

Budget Section	Expense Total
Program Salaries	$3259694.05
Tax and Fringe Benefits	$749,729.63
Total Program Operating Expenses	$519,696.00
Cost Adjustment Factor	$317,038.38

Grand Total	$4,846,158.06

Total Daily Rate per Student	$448.72

1:4 TO 1:7 TEACHER, 1:2 OR 1:3 TEACHER AIDE BUDGET

Program Personnel Salaries	Hourly Wage	FTE	Full Time Hours	Expense
Administrators	$34.48	1.20	2080	$86,062.08
Teachers	$25.55	12.00	2080	$637,728.00
Teacher Aides	$16.75	24.00	2080	$836,160.00
Other Direct Student Report Staff (Bachelors)	$21.22	1.20	2080	$52,965.12
Other Direct Student Report Staff (Masters)	$27.69	2.40	2080	$138,228.48
Medical Staff	$21.92	2.40	2080	$109,424.64
Trade Staff	$19.16	1.00	2080	$39,852.80
Teacher Relief	$25.55	0.462	2080	$24,552.53
Teacher Aide Relief	$16.75	0.924	2080	$32,192.16

Tax and Fringe	Percent of Staff Salary	Expense
	23%	$450,148.14

Other Operating Expenses	Per Student Per Day	Teacher and Aide FTEs	Per Teacher Cost	Expense
Training Expenses for Teachers and Aides	$2.51	36.00	$754.36	$27,156.96
Travel Expenses (i.e. mileage)	$0.67	N/A	N/A	$7,236.00
Vehicle Expenses	$1.22	N/A	N/A	$13,176.00
Occupancy/Facility (mortgage, rent, etc.)	$24.51	N/A	N/A	$264,708.00
Student Technology	$1.19	N/A	N/A	$12,852.00
Classroom Supplies	$3.61	N/A	N/A	$38,988.00
Program Equipment	$1.94	N/A	N/A	$20,952.00
Insurance	$2.54	N/A	N/A	$27,432.00
Translation/Interpretation Services	$2.25	N/A	N/A	$24,300.00
Other Costs	$5.16	N/A	N/A	$55,728.00

Cost Adjustment Factor (CAF)	$202,985.58

Budget Section	Expense Total
Program Salaries	$1,957,165.81
Tax and Fringe Benefits	$450,148.14
Total Program Operating Expenses	$492,480.00
Cost Adjustment Factor	$202,985.58

Grand Total	$3,102,779.53

Total Daily Rate per Student	$287.29

1:4 TO 1:7 TEACHER, 1:4 OR MORE TEACHER AIDE BUDGET

Program Personnel Salaries	Hourly Wage	FTE	Full Time Hours	Expense
Administrators	$34.48	1.20	2080	$86,062.08
Teachers	$25.55	12.00	2080	$637,728.00
Teacher Aides	$16.75	15.00	2080	$522,600.00
Other Direct Student Report Staff (Bachelors)	$21.22	1.20	2080	$52,965.12
Other Direct Student Report Staff (Masters)	$27.69	2.40	2080	$138,228.48
Medical Staff	$21.92	2.40	2080	$109,424.64
Trade Staff	$19.16	1.00	2080	$39,852.80
Teacher Relief	$25.55	0.4620	2080	$24,552.53
Teacher Aide Relief	$16.75	0.5775	2080	$20,120.10

Tax and Fringe	Percent of Staff Salary	Expense
	23%	$375,252.76

Other Operating Expenses	Per Student Per Day	Teacher and Aide FTEs	Per Teacher Cost	Expense
Training Expenses for Teachers and Aides	$1.89	27.00	$754.36	$20,367.72
Travel Expenses (i.e. mileage)	$0.67	N/A	N/A	$7,236.00
Vehicle Expenses	$1.22	N/A	N/A	$13,176.00
Occupancy/Facility (mortgage, rent, etc.)	$24.51	N/A	N/A	$264,708.00
Student Technology	$1.19	N/A	N/A	$12,852.00
Classroom Supplies	$3.61	N/A	N/A	$38,988.00
Program Equipment	$1.94	N/A	N/A	$20,952.00
Insurance	$2.54	N/A	N/A	$27,432.00
Translation/Interpretation Services	$2.25	N/A	N/A	$24,300.00
Other Costs	$5.16	N/A	N/A	$55,728.00

Cost Adjustment Factor (CAF)	$317,038.38

Budget Section	Expense Total
Program Salaries	$1,631,533.75
Tax and Fringe Benefits	$375,252.76
Total Program Operating Expenses	$485,784.00
Cost Adjustment Factor	$174,479.94

Grand Total	$2,667,050.45

Total Daily Rate per Student	$246.95

1:8 OR MORE TEACHER, 1:1 TEACHER AIDE BUDGET

Program Personnel Salaries	Hourly Wage	FTE	Full Time Hours	Expense
Administrators	$34.48	1.20	2080	$86,062.08
Teachers	$25.55	7.50	2080	$398,580.00
Teacher Aides	$16.75	60.00	2080	$2,090,400.00
Other Direct Student Report Staff (Bachelors)	$21.22	1.20	2080	$52,965.12
Other Direct Student Report Staff (Masters)	$27.69	2.40	2080	$138,228.48
Medical Staff	$21.92	2.40	2080	$109,424.64
Trade Staff	$19.16	1.00	2080	$39,852.80
Teacher Relief	$25.55	0.28875	2080	$15,345.33
Teacher Aide Relief	$16.75	2.310	2080	$80,480.40

Tax and Fringe	Percent of Staff Salary	Expense
	23%	$692,607.94

Other Operating Expenses	Per Student Per Day	Teacher and Aide FTEs	Per Teacher Cost	Expense
Training Expenses for Teachers and Aides	$4.71	67.50	$754.36	$50,919.30
Travel Expenses (i.e. mileage)	$0.67	N/A	N/A	$7,236.00
Vehicle Expenses	$1.22	N/A	N/A	$13,176.00
Occupancy/Facility (mortgage, rent, etc.)	$24.51	N/A	N/A	$264,708.00
Student Technology	$1.19	N/A	N/A	$12,852.00
Classroom Supplies	$3.61	N/A	N/A	$38,988.00
Program Equipment	$1.94	N/A	N/A	$20,952.00
Insurance	$2.54	N/A	N/A	$27,432.00
Translation/Interpretation Services	$2.25	N/A	N/A	$24,300.00
Other Costs	$5.16	N/A	N/A	$55,728.00

Cost Adjustment Factor (CAF)	$295,413.08

Budget Section	Expense Total
Program Salaries	$3,011,338.85
Tax and Fringe Benefits	$692,607.94
Total Program Operating Expenses	$516,240.00
Cost Adjustment Factor	$295,413.08

Grand Total	$4,515,599.87

Total Daily Rate per Student	$418.11

1:8 OR MORE TEACHER, 1:2 OR 1:3 TEACHER AIDE BUDGET

Program Personnel Salaries	Hourly Wage	FTE	Full Time Hours	Expense
Administrators	$34.48	1.20	2080	$86,062.08
Teachers	$25.55	7.50	2080	$398,580.00
Teacher Aides	$16.75	24.00	2080	$836,160.00
Other Direct Student Report Staff (Bachelors)	$21.22	1.20	2080	$52,965.12
Other Direct Student Report Staff (Masters)	$27.69	2.40	2080	$138,228.48
Medical Staff	$21.92	2.40	2080	$109,424.64
Trade Staff	$19.16	1.00	2080	$39,852.80
Teacher Relief	$25.55	0.28875	2080	$15,345.33
Teacher Aide Relief	$16.75	0.924	2080	$32,192.16

Tax and Fringe	Percent of Staff Salary	Expense
	23%	$393,026.44

Other Operating Expenses	Per Student Per Day	Teacher and Aide FTEs	Per Teacher Cost	Expense
Training Expenses for Teachers and Aides	$2.20	31.50	$754.36	$23,762.34
Travel Expenses (i.e. mileage)	$0.67	N/A	N/A	$7,236.00
Vehicle Expenses	$1.22	N/A	N/A	$13,176.00
Occupancy/Facility (mortgage, rent, etc.)	$24.51	N/A	N/A	$264,708.00
Student Technology	$1.19	N/A	N/A	$12,852.00
Classroom Supplies	$3.61	N/A	N/A	$38,988.00
Program Equipment	$1.94	N/A	N/A	$20,952.00
Insurance	$2.54	N/A	N/A	$27,432.00
Translation/Interpretation Services	$2.25	N/A	N/A	$24,300.00
Other Costs	$5.16	N/A	N/A	$55,728.00

Cost Adjustment Factor (CAF)	$181,367.83

Budget Section	Expense Total
Program Salaries	$1,708,810.61
Tax and Fringe Benefits	$393,026.44
Total Program Operating Expenses	$489,132.00
Cost Adjustment Factor	$181,367.83

Grand Total	$2,772,336.88

Total Daily Rate per Student	$256.70

1:8 OR MORE TEACHER, 1:4 OR MORE TEACHER AIDE BUDGET

Program Personnel Salaries	Hourly Wage	FTE	Full Time Hours	Expense
Administrators	$34.48	1.20	2080	$86,062.08
Teachers	$25.55	7.50	2080	$398,580.00
Teacher Aides	$16.75	15.00	2080	$522,600.00
Other Direct Student Report Staff (Bachelors)	$21.22	1.20	2080	$52,965.12
Other Direct Student Report Staff (Masters)	$27.69	2.40	2080	$138,228.48
Medical Staff	$21.92	2.40	2080	$109,424.64
Trade Staff	$19.16	1.00	2080	$39,852.80
Teacher Relief	$25.55	0.28875	2080	$15,345.33
Teacher Aide Relief	$16.75	0.5775	2080	$20,120.10

Tax and Fringe	Percent of Staff Salary	Expense
	23%	$318,131.07

Other Operating Expenses	Per Student Per Day	Teacher and Aide FTEs	Per Teacher Cost	Expense
Training Expenses for Teachers and Aides	$1.57	22.50	$754.36	$16,973.10
Travel Expenses (i.e. mileage)	$0.67	N/A	N/A	$7,236.00
Vehicle Expenses	$1.22	N/A	N/A	$13,176.00
Occupancy/Facility (mortgage, rent, etc.)	$24.51	N/A	N/A	$264,708.00
Student Technology	$1.19	N/A	N/A	$12,852.00
Classroom Supplies	$3.61	N/A	N/A	$38,988.00
Program Equipment	$1.94	N/A	N/A	$20,952.00
Insurance	$2.54	N/A	N/A	$27,432.00
Translation/Interpretation Services	$2.25	N/A	N/A	$24,300.00
Other Costs	$5.16	N/A	N/A	$55,728.00

Cost Adjustment Factor (CAF)	$152,854.63

Budget Section	Expense Total
Program Salaries	$1,383,178.55
Tax and Fringe Benefits	$318,131.07
Total Program Operating Expenses	$482,328.00
Cost Adjustment Factor	$152,854.63

Grand Total	$2,336,492.25

Total Daily Rate per Student	$216.34

MEMO TO THE CPMT
July 29, 2022

Information Item I-4: Procedure for Access to Foster Care Maintenance/ KinGAP funding

ISSUE: That Foster Care staff have the ability to receive authorizations for KinGAP maintenance funding for eligible youth in an expedited and simplified manner similar to other foster care maintenance payments.

BACKGROUND: The 2018 General Assembly enacted legislation establishing the Virginia Kinship Guardianship Program (KinGAP) with implementation effective July 1, 2018 (COV *§63.2-1305*, *§63.2-100* and *§63.2-905*). KinGAP is an agreement between the Department of Family Services and the relative caregiver. KinGAP facilitates the placement of children with relatives and provides a supported permanency option for foster children for whom return home or adoption are not appropriate goals. KinGAP assistance includes the basic maintenance and enhanced maintenance payment.

The funding source for the KinGAP agreements follows the youth's financial determination while in foster care. If the youth was Title IV-E eligible in foster care, the youth is automatically Title IV-E eligible for KinGAP. If the youth was non-Title IV-E while in foster care, CSA state pool funds are used for the basic maintenance and enhanced maintenance payments in the KinGAP agreement. The KinGAP agreement begins on the date of custody transfer and continues until the youth's 18th birthday, but it may continue until the youth's 21st birthday if the youth has a physical or mental disability and requires ongoing treatment or intervention.

FISCAL IMPACT: Currently, there are 17 KinGAP cases open. Of those 17, 15 are CSA funded and 2 are IV-E funded with federal dollars. The monthly rate or cost is the same as the foster care maintenance rate established by the Virginia Department of Social Services (VDSS). There are 30 children/youth placed in relative homes. Of those children, some will proceed with an adoption assistance agreement and others will be KinGAP cases. However, all 30 could be eligible for KinGAP, but not all will likely be KinGAP cases. Adoption is still considered a higher permanency goal than KinGAP.

ATTACHMENT: Proposed local policy manual changes

STAFF:
Sarah Young, CSA
Kamonya Omatete, FC&A

Attachment: Local Policy Manual – page 60

Services Eligible for Expedited FAPT Services Planning

FAPT reviews requests for services specified on the IFSP-EZ form and can provide expedited team-based service planning on a limited basis. Services are not authorized to begin prior to review of complete documentation by the FAPT.

3. For children in foster care and children at-risk of entering foster care served by the Department of Family Services Children, Youth and Families Division, the following services may be requested with standard language incorporated in the IFSP/MAP. The use of standard language incorporated in the IFSP/MAP or the IFSP-EZ to request services for children at-risk of entering foster care served by DFS CYF is limited to six months after the initial CSA service approval.

Service	Foster Care	CPS/PPS/Kinship*
Camp/Socialization/Recreation programs and activities	✓	✓
Summer youth employment programs	✓	✓
Youth & family travel costs for visitation, appointments and training related to the IFSP/MAP or foster care service plan (not for Medicaid or IV-E eligible expenses)	✓	✓
Parenting and anger management classes	✓	✓
Family Partnership Meetings	✓	✓
Translation/Interpretation services to support clinical services only	✓	✓
Court testimony (8 hours per subpoenaed provider per day per hearing; not for expert testimony)	✓	✓
Respite (in-home and out of home)	30 days/year maximum	Maximum of $5,000 and/or 15 calendar days over 6 months and not to exceed 14 consecutive days out of home
Non-Medicaid reimbursable medical expenses excluding behavioral health care services	✓	$1,000 annual maximum
KinGap Maintenance Payments	✓	*NA*
Acute hospitalization not covered by Medicaid	14 consecutive days maximum per episode	NA
Emergency Supervision and Support	*7 days/125 hrs maximum per episode*	*NA*
Legal fees	✓	NA
Driver's education	✓	NA
School-related fees (excluding private school tuition)	✓	NA
Out-of-State public school tuition	✓	NA
Foster/adoptive home studies	✓	NA

Service	Foster Care	CPS/PPS/Kinship*
Court-ordered evaluations/assessments from CSA-contracted providers	✓	NA
Tutoring	$3,000/year max	NA
***reference UR service authorization note for eligible dates of service**		

Kinship Guardianship Assistance Program (KinGap) ***policy manual pg. 36***

The 2018 General Assembly enacted legislation establishing the Virginia Kinship Guardianship Assistance Program (KinGap) with implementation effective July 1, 2018 (COV *§63.2-1305*, *§63.2-100* and *§63.2-905*). KinGap is an agreement between the Department of Family Services and the relative caregiver. KinGap facilitates the placement of children with relatives and provides a supported permanency option for foster children for whom return home or adoption are not appropriate goals. KinGap assistance includes the basic maintenance and enhanced maintenance payment.

Procedures for Authorizing KinGap:

- The funding source for the KinGAP agreements follows the youth's financial determination while in foster care. If the youth was Title IV-E eligible in foster care, the youth is automatically Title IV-E eligible for KinGAP. If the youth was non-Title IV-E while in foster care, CSA state pool funds are used for the basic maintenance and enhanced maintenance payments in the KinGAP agreement.
- The KinGAP agreement begins on the date of custody transfer and continues until the youth's 18th birthday, but it may continue until the youth's 21st birthday if the youth has a physical or mental disability and requires ongoing treatment or intervention.
- *CSA funding for KinGap placements for foster care youth may be accessed through standard language incorporated in the IFSP*
- if additional services are needed, KinGap children, youth and families ~~will be referred to the Family Assessment and Planning Team (FAPT)~~ *can be served via the current MDT process for requesting CSA funding.*