

**Report of the
Joint Legislative Audit and Review Commission
To the Governor and
The General Assembly of Virginia**

**Evaluation of Children's
Residential Services
Delivered Through the
Comprehensive Services Act**



**HOUSE DOCUMENT NO. 12
2007**

In Brief

Evaluation of Children's Residential Services Delivered Through the Comprehensive Services Act

House Joint Resolution 60 (2006) directed JLARC staff to evaluate the quality and cost of children's residential services delivered through the Comprehensive Services Act.

JLARC staff found that Virginia's regulatory environment does not appear to adequately protect the health and safety of children. Further, CSA children appear to experience mixed outcomes after receiving residential care, indicating that these costly services may not be consistently effective. While many providers already exceed minimum requirements, strengthening licensing standards and enforcement efforts could help ensure that all residential facilities provide a level of care sufficient to promote child safety and positive outcomes.

This report also identifies strategies that could be used to better control the cost of residential services and allow more children to be served in their homes and communities. Addressing gaps in the availability of community-based and foster care services could reduce program costs by decreasing the frequency of residential placements for children who can safely and effectively be served in the community. In addition, improving access to reliable information about the rates charged and services provided by residential facilities could enhance market efficiency and control rates without formal mechanisms such as rate setting. Greater resources and guidance could also help local CSA programs maximize resources and address children's problems in the most cost-effective manner.

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January 10, 2007

The Honorable Thomas K. Norment, Jr.
Chairman
Joint Legislative Audit and Review Commission
General Assembly Building
Richmond, Virginia 23219

Dear Senator Norment:

House Joint Resolution 60 enacted by the 2006 General Assembly directed JLARC to evaluate the administration of the Comprehensive Services Act. Staff were directed to evaluate the cost, quality, and reimbursement of residential services and the adequacy of regulations designed to protect children's health and safety in residential facilities.

On behalf of the Commission staff, I would like to thank the staff at the Office of Comprehensive Services and the Departments of Social Services; Mental Health, Mental Retardation and Substance Abuse Services; Juvenile Justice; and Education as well as local CSA staff for their assistance during this study.

Sincerely,

A handwritten signature in black ink that reads "Philip A. Leone".

Philip A. Leone
Director

Table of Contents

Report Summary	i
1 Overview of the Comprehensive Services Act and Regulation of Residential Facilities	1
Overview of the Comprehensive Services Act	2
Local CSA Programs Are Funded by Multiple Funding Streams	6
Profile of CSA Participants	8
Profile of Children's Residential Facilities	13
Licensing System	16
Regulatory Standards	20
2 Regulatory Environment Appears Inadequate to Ensure Children's Health and Safety	25
Inadequate Enforcement May Undermine Provider Accountability and Compromise Safety	26
Greater Resources, Clarity, and Authority May Improve Oversight	34
Licensing Standards Could Be Strengthened	42
History of Violations and Fatalities Underscores Need for Improving Virginia's Regulatory Process	52
3 State Lacks Mechanisms to Promote Effectiveness of Residential Services	57
Absence of Outcome Measures and Usable Information Undermines Understanding of Program Effectiveness	57
Majority of Children Appear to Improve, but Many Still Do Not Progress	61
Effectiveness of Residential Services Could Be Strengthened Through Stronger Standards, Better Information, and Greater Accountability	65
4 Residential Expenditures and Overall Program Spending	73
Total Cost of Services Provided to CSA Participants Stretches Beyond Pool Funding	73
Residential Services Account for Largest Portion of CSA Program Expenditures	75

	Spending Increases for Residential Services Driven Largely by Program Caseload and Rates	79
	Reducing Residential Placements and Managing Residential Stays Would Maximize Savings	87
5	Gaps in Services for Children Limit Cost Effectiveness of CSA Program	93
	Limited Availability of Some Services Hinders Local CSA Programs From Securing the Most Appropriate and Cost-Effective Services	94
	Gaps in Community-Based Services Undermine CSA Goals	98
	Lack of Foster Families Is a Frequently Cited Service Gap	107
	Lack of Residential Services May Undermine Child Progress and Preclude Returns to Community	117
	Lack of Local Services Results in Placements Outside of Community	120
6	Rates Charged by Residential Facilities Not Consistently Regulated by Market Forces	125
	Rates of For-Profit Group Homes Do Not Appear Strongly Associated With Intensity of Services	125
	Lack of Information May Distort Rates and Lead to Inappropriate Placements	131
	Centralized Negotiations Could Create Greater Leverage and Facilitate Rate Differentiation	138
	Rate Setting May Be Considered	139
7	Greater Resources and Process Improvements Could Strengthen CSA Oversight	143
	Local CSA Programs Generally Develop Appropriate Service Plans for Eligible Children	143
	Additional State Resources and Training Could Improve Accountability and Efficiency in Local CSA Service Planning	147
Appendixes		
	A: Study Mandate	167
	B: Research Activities & Methods	171
	C: Acronyms	183
	D. Agency Responses	187



JLARC Report Summary:

Evaluation of Children's Residential Services Delivered Through the Comprehensive Services Act

Key Findings

- The State's process for licensing and enforcing compliance in residential facilities does not appear to adequately support children's health and safety. Licensing standards and enforcement efforts need to be improved to ensure that all providers are held to a minimum level of care that better ensures the safety of children. (Chapter 2)
- Limited information currently exists to assess whether residential providers effectively address the emotional and behavioral problems of Virginia's children, but available data suggest mixed results. (Chapter 3)
- The CSA program served 16,272 children in 2005, one-quarter of whom received residential services that cost approximately \$194 million. Mechanisms that better control expenditures for residential services will likely yield the largest savings to the State because these services account for the majority of program spending. (Chapter 4)
- Addressing gaps in the availability of community-based services would reduce program costs by decreasing the frequency of residential placements for children who can effectively and safely be served in the community. In addition, a more complete continuum of care would help children access the services best suited to meet their needs and realize the CSA program's original intent of serving youths in their homes and communities. (Chapter 5)
- Most children's residential facilities appear to charge rates commensurate with the scope of their services and experience limited profitability, but some providers may charge high rates and realize excessive profit margins. Improving access to reliable information could enhance market efficiency without the need to resort to more formal mechanisms such as rate setting. (Chapter 6)
- Although local CSA staff generally develop appropriate service plans, greater State resources for program administration coupled with additional guidance on prioritizing responsibilities would enhance accountability and help local CSA programs to better meet children's needs in the most cost-effective and efficient manner. (Chapter 7)

The Comprehensive Services Act (CSA) was adopted by the General Assembly in 1992 to improve the delivery of services to children with serious emotional and behavioral problems and their families. In addition, the CSA was intended to better control costs of delivering these services by affording localities greater flexibility and promoting cross-agency collaboration. While costs are not growing as rapidly, and most stakeholders agree that collaboration

has increased since the passage of the CSA, opportunities remain to fully realize the program's original promise. Specifically, the outcomes of CSA participants are largely unknown, growing program spending continues to strain State and local budgets, and many children are not being served in their homes and communities. Furthermore, concerns have been raised about the adequacy of licensing standards and regulatory processes to ensure the quality of children's residential facilities, particularly given their high cost. In response to these concerns, House Joint Resolution 60 of the 2006 General Assembly directed the Joint Legislative Audit and Review Commission (JLARC) to evaluate the administration of the CSA (Appendix A).

REGULATORY ENVIRONMENT MAY BE INADEQUATE TO ENSURE CHILDREN'S HEALTH AND SAFETY IN RESIDENTIAL FACILITIES

The State's process for licensing and enforcing compliance in residential facilities does not appear to adequately support children's basic health and safety. The convergence of a strong consensus among licensing staff, Virginia providers' practices, other states' requirements, and national recommendations points to the need for stronger standards and greater enforcement efforts to ensure the health and safety of children in residential facilities. Moreover, the occurrence of serious incidents and 12 deaths in a five-year period are further indicators that there is reason to be concerned about the regulatory process that oversees children's residential facilities. While greater enforcement efforts cannot prevent every incident from occurring, and more stringent standards will not guarantee that all children are consistently kept safe, these two mechanisms are the State's primary means to minimize incidents that jeopardize the health and safety of children.

Inadequate Enforcement May Undermine Provider Accountability and Compromise Safety

To effectively hold providers accountable for meeting licensure requirements, standards must be properly and consistently enforced by licensing agencies. However, data from licensing agencies as well as interviews with their staff suggest that enforcement efforts may not be adequate to ensure child safety. Agencies do not complete all required inspections, and those completed may not be thorough enough for agencies to identify compliance problems. Furthermore, when agencies identify violations, they do not appear to always take effective enforcement action to bring providers into compliance. As a result of inadequate enforcement, some children's residential facilities may operate below minimum licensing requirements, thereby threatening residents' health and safety.

To provide greater oversight, licensing agencies may need more resources, clearer policies, and greater transparency of the enforcement process. As a result, this report recommends that

- licensing divisions assess and document the need for additional resources to conduct all required inspections;
- the interdepartmental program develop clearer policies that better establish agencies' authority to take enforcement action against non-compliant providers; and
- licensing divisions periodically report to the CSA State Executive Council about facilities with severe compliance problems and actions taken to increase transparency and accountability of enforcement decisions.

Health and Safety of Children Do Not Appear to Be Adequately Preserved by Licensing Standards

Current regulations, even if properly enforced, do not appear to be sufficient to consistently preserve the health and safety of children in residential facilities. Based on extensive input from licensing staff, a review of other states' standards, the recommendations of national experts, and the practices of many Virginia providers, the minimum requirements set forth in interdepartmental standards appear too low in several areas that are critical to residents' health and safety.

Required staffing ratios may be too low to prevent incidents which could compromise the safety of residents. Further, standards do not appear to satisfactorily address the need for supervision of direct care staff who may therefore be left to handle difficult situations without proper guidance or reinforcement. In addition, staff may lack the qualifications or training to prepare them for the challenges they face in serving children with complex mental or emotional problems. Staff who are not properly qualified or trained may lack the skills to recognize emerging problems, handle crises, and generally respond to issues that can compromise residents' safety.

Although providers often choose to exceed standards, standards need to be designed to guarantee that providers who only comply with their minimum requirements will still adequately protect children's safety. If standards fail to establish an appropriate baseline, some facilities will continue to operate even though they may not have the capability or commitment to serve children in a safe environment, and the State will lack the authority to take action. Consequently, clearer and stronger standards appear to be needed to ensure that all residential facilities provide a minimum level of care sufficient to at least ensure the safety of each child.

Revisions to the interdepartmental standards were proposed more than two years ago to address many of these shortcomings, but these proposed regulations have not been released for public comment. To address deficiencies in current licensing standards, this report recommends that

- the Governor consider releasing previously proposed regulations and approving emergency regulations relating to standards in children's residential facilities (emergency regulations were approved December 28, 2006), and
- the boards of the four licensing agencies direct staff to develop additional proposed regulations that address the findings in this report that are not addressed in either the proposed or emergency regulations.

ABSENCE OF OUTCOME MEASURES AND USABLE INFORMATION UNDERMINES UNDERSTANDING OF PROGRAM EFFECTIVENESS

Despite their importance for assessing program effectiveness, there is currently no system for measuring the outcomes of children who receive CSA services at the State level, and few local CSA programs formally track the outcomes of children they serve. As a result, it is difficult to gauge the extent to which CSA services have addressed children's individual needs or whether CSA funding has been well spent. Given the importance of developing performance measures, the State Executive Council (SEC) and the State and Local Advisory Team (SLAT) have been working with staff of the Office of Comprehensive Services (OCS), local CSA programs, and service providers to develop and implement outcome measures.

While OCS already collects information that could be used to track some of the proposed outcome measures, there are concerns over its accuracy and completeness. Changes in children's scores on the Child and Adolescent Functional Assessment Scale (CAFAS) could be used to measure changes in child functioning, but local staff have raised concerns that many case managers lack training to use this instrument, and JLARC staff found that scores are missing for a large number of children. In addition, greater context is needed in order to accurately interpret when changes in services are positive indicators. To address these concerns, this report recommends

- providing more frequent training on conducting standardized assessments, and
- adding a field to the CSA child-level dataset that captures the reason why services ended.

EFFECTIVENESS OF RESIDENTIAL SERVICES APPEARS MIXED

Based on available information, it appears that many CSA participants experience improvements after receiving residential services. However, a substantial number of children do not appear to improve, and some children even regress. Analyses of CAFAS scores indicate that although more than half of children who received residential services appeared to be doing better over time, nearly one-third were doing worse and the remainder were functioning at the same level. In addition, the vast majority of children continued to be served in the same residential setting rather than stepping down to a less restrictive environment. Results from a JLARC staff survey of case managers indicate that the majority of children improved after receiving residential care. However, 20 percent of children ran away or engaged in illegal activities more frequently than before they received residential services. Local CSA program staff and case managers appear satisfied with the effectiveness of residential services offered by the majority of providers, but have concerns about some facilities.

To enhance the effectiveness of residential services and maximize Virginia's investment in this costly service, steps could be taken to revise licensing standards to ensure that programs are appropriately structured to deliver effective services. Under current standards, staff may lack adequate qualifications and/or training to develop and implement service plans that are needed to address the behavioral and emotional problems of residents. Staff qualifications and training are two factors that Virginia providers identified as critical to the quality of services, yet current requirements fall below those of several neighboring states and national recommendations. To address these deficiencies, this report recommends that

- the boards of the four licensing agencies direct relevant staff to develop additional proposed regulations that address the findings in this report.

In addition to using regulatory means, the State could better hold providers accountable for delivering effective services by collecting more information. Information about provider effectiveness is currently not captured in a systematic manner and therefore cannot be used to hold providers accountable for their performance. To address this issue, this report recommends

- modifying local service contracts to require providers to report performance on a specific set of outcome measures, and

- adding a field to the CSA child-level dataset to identify the specific residential facility where each child was placed and measure child outcomes by facility.

MANAGEMENT OF CSA PROGRAM SPENDING SHOULD EXTEND BEYOND POOL FUNDING

The total cost of serving CSA participants includes not only pool expenditures but also services funded through the Medicaid and Title IV-E programs. However, CSA program spending is generally characterized only as pool funding, which accounted for two-thirds of the \$416 million spent to serve at-risk and troubled children across these three funding streams in FY 2005. This approach does not present a complete picture of program spending and therefore makes it difficult to understand and control rising expenditures. In order for the State to make informed decisions about the program, this report recommends that

- the General Assembly consider requiring OCS to report all Medicaid and Title IV-E expenditures associated with children who receive pool-funded services,
- the CSA's State Executive Council (SEC) decide which at-risk and troubled children should be included within the scope of the CSA program as the first step to identifying the total cost of serving these children, and
- detailed information be reported about the specific services provided to the children through all funding streams that are identified by the SEC as part of the CSA program.

RECENT INCREASES IN RESIDENTIAL EXPENDITURES DRIVEN LARGELY BY CSA CASELOAD AND RATES

Since the program's inception, residential services have accounted for the majority of CSA spending and represented at least 54 percent of expenditures in 2006. Even though residential services are not as commonly utilized, they account for a greater share of program expenditures because they usually cost more than services provided in the community. On average, residential care is four times as costly as community-based services, in part because it is generally reserved for children with more complex needs.

During the first nine months of 2006, residential expenditures rose by \$2.5 million compared to the same period in 2005 (a two percent increase). This increase was driven by two primary factors. First, the CSA program's caseload grew by four percent during that period. This increase can largely be attributed to changes in population and can be difficult to control because children who are man-

dated for services cannot be turned away. Second, the rates charged by residential providers grew by 5.7 percent, on average. Most facilities that raised rates seemingly did so because they were attempting to keep pace with rising expenses or had lost money in the previous year. The full extent of this growth in residential expenditures was mitigated by a shorter average length of stay and lower utilization of residential services.

Because residential services are by far the most costly, mechanisms that seek to manage residential expenditures will likely yield the largest fiscal impact. In particular, modest changes in several areas could greatly reduce spending on residential services and partially offset the cost of serving more children. Chapters 5 through 7 of this report provide evidence that improvements could be made in each of these areas, and advance recommendations for addressing current shortcomings. For example, Virginia could realize annual savings of \$1 million for each of the following measures:

- avoiding residential placements for 34 children who can safely and effectively be served in the community;
- serving 62 children in a group home rather than in a more restrictive residential treatment facility, when appropriate;
- reducing every child's length of stay in residential programs by 0.8 days; or
- negotiating an average decrease of \$1.53 in the daily rates charged by residential providers.

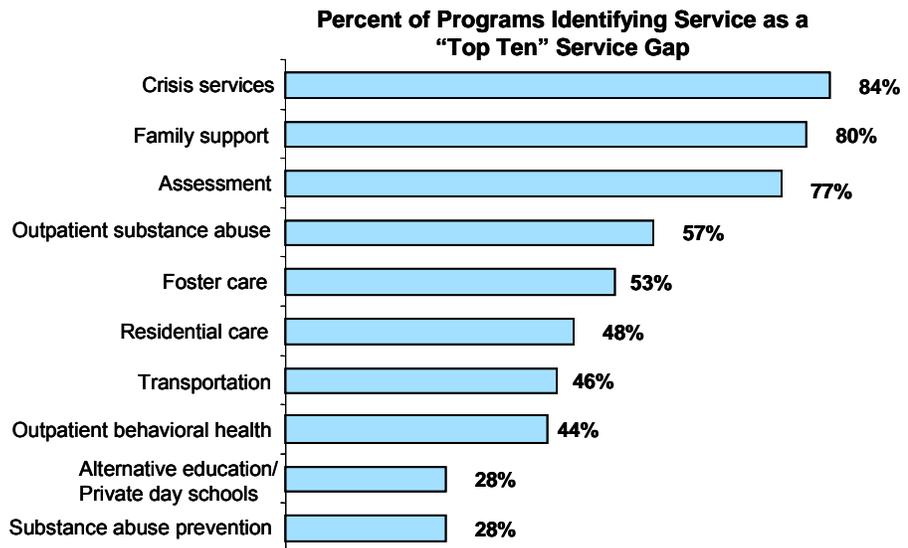
GAPS IN SERVICES FOR CHILDREN UNDERMINE CSA PROGRAM'S COST-EFFECTIVENESS

Addressing gaps in the availability of community-based services could help reduce program costs while linking children with more appropriate services to meet their needs. Most of the CSA staff interviewed and surveyed by JLARC staff reported instances in which CSA children receive costly services that are unnecessarily intensive or unduly restrictive as a result of service gaps in their continuum of care. Because it is more than four times as expensive to serve a child in a residential environment than in the community, serving even a few children in a setting that is overly restrictive can quickly escalate program costs. In addition, children's experience with CSA services can be adversely impacted because inappropriate service decisions reportedly lead to a greater number of different placements; inhibit children's transition back to their homes, schools, and communities from more restrictive environments; and exacerbate their already tenuous emotional and behavioral stability. Furthermore, service gaps appear to be the primary obstacle to more fully realizing the original intent of the

CSA, which is to connect children with the most appropriate services to meet their needs in the least restrictive setting.

Based on an analysis of local responses to JLARC's statewide needs assessment survey, community-based services are the most common type of services that are lacking. In particular, local Community Policy and Management Teams (CPMTs) noted that crisis intervention, family support, and psychiatric assessment services are lacking for CSA children, either because services are nonexistent or do not have sufficient capacity to meet demand. CPMTs also cited family-based foster care services as one of the top ten service gaps in their communities, either because there are no families available or because the demand for foster families exceeds their availability.

Top Ten Service Gaps Identified by Local CSA Programs



Source: JLARC staff survey of CPMT chairpersons.

Gaps also exist in residential services for CSA children. Residential care is especially appropriate for children who have highly complex emotional and behavioral needs or who present a threat to themselves or others. Although nearly 300 children's residential facilities are licensed to operate in Virginia, most are concentrated in only a few regions of the State. As a result, many children in need of residential care may be sent far from their homes and communities. In addition, children may remain in residential treatment facilities if less-intensive group homes are not available.

Both of these scenarios can undermine children's well-being and lead to unnecessary costs. Moreover, localities that host a large

number of residential facilities may experience strained public infrastructures and bear costs not generally reimbursed through the CSA program.

Efforts to address gaps in critical children's services could be bolstered by greater State financial assistance and by forging new partnerships with the private provider community. This report includes recommendations for the State to consider improving the availability of services for CSA children by

- expanding competitive grants to help localities develop new services,
- allowing localities to reinvest costs avoided by greater use of community services into the start-up of new services, and
- assuming a portion of the financial risk of developing capital-intensive services.

In addition, options are included to address the statewide shortage of regular foster families. Specifically, the State could consider the benefits and drawbacks of

- issuing a request for proposals to train and recruit foster families,
- increasing compensation for regular foster families to properly reflect the demands of caring for children,
- expanding the public sector's capacity to recruit, train, and support regular foster families, and/or
- entering into a public/private partnership to leverage the existing expertise and infrastructure by the private child placing agencies that manage the therapeutic foster care system.

RESIDENTIAL FACILITIES' MARKET NOT OPERATING EFFICIENTLY DUE TO LACK OF INFORMATION

Analyses of residential providers' financial statements suggest that the majority of facilities are charging rates commensurate with the scope of services they provide and most generate moderate profits or even financial losses. Yet, some facilities appear to be charging more than the nature and intensity of their services would warrant. In particular, rates charged by for-profit group homes have the weakest association with the scope and quality of services offered in these facilities. In contrast, residential treatment facilities and nonprofit group homes that charge higher rates appear to usually offer more intensive and comprehensive services. Another source of concern is that some children's residential facilities earn profit margins that appear excessive compared to most

other U.S. industries. In particular, nearly 30 percent of for-profit group homes realized after-tax profit margins in excess of 20 percent in 2005 whereas only two percent of residential treatment facilities and nonprofit group homes achieved this level of profitability.

While the use of facilities that may not be consistently cost-effective should be of concern to the State and local governments, for-profit group homes received only ten percent of all public revenues spent in facilities that responded to a JLARC staff survey. Moreover, it is unclear whether high levels of profitability are consistently the result of concerted efforts to boost profit margins or occur due to volatility in market conditions and financial assumptions. Consequently, returning to a rate setting process may not be necessary. Instead, the State could facilitate better purchasing decisions by improving the availability and accuracy of information about residential providers.

Insufficient information enables some residential providers to charge higher rates than may be justified and in some instances realize high profit margins. Currently, local CSA staff have no reliable source of information to compare the costs of similar children's services against individual program characteristics, effectiveness, and compliance record. As a result, staff cannot adequately assess providers' cost-effectiveness and identify which programs best meet individual children's needs. To improve market efficiency and connect children with the most appropriate services, this report includes a recommendation for OCS to collaborate with the Secretary of Health and Human Resources and the Secretary of Technology to develop a comprehensive information system that would replace the Service Fee Directory and capture key compliance, performance, and financial information about residential services.

LOCAL CSA PROGRAMS GENERALLY DEVELOP APPROPRIATE SERVICE PLANS FOR ELIGIBLE CHILDREN

While some policymakers have expressed concerns about the increasing number of CSA children receiving services outside of their homes and communities, it appears that local CSA programs do focus on serving children in the most appropriate setting for their needs. When children are placed in service settings that are more intensive or restrictive than necessary to meet their needs, this is primarily due to factors that are not within the control of local program staff, such as the lack of more appropriate community-based alternatives. Additionally, concerns that local programs are liberally interpreting certain CSA eligibility guidelines to secure services for children who might otherwise not receive services

seem unwarranted. This does not appear to be a widespread practice and also does not have a substantial impact on CSA caseloads.

CSA STAKEHOLDERS REPORT INADEQUATE STATE FUNDING FOR PROGRAM'S LOCAL INFRASTRUCTURE

Given the complex needs of the children and families served by the CSA and the fact that the average cost to serve a single CSA child in FY 2005 was more than \$21,000 (excluding Title IV-E and Adoption Assistance funding), a strong local management structure is needed to ensure proper oversight of the program. However, there is a general consensus among State and local CSA program staff that General Fund allocations for local administrative costs are inadequate to support well-managed and accountable local programs.

In most localities, CSA coordinators conduct much of the CSA program's oversight. Some localities have also hired staff specifically to perform utilization management and review (UM/UR) for CSA cases. The ability to hire staff for these positions appears to positively impact program costs and children's well-being. Specifically, programs with a CSA coordinator tend to spend about \$14,000 less annually for each child in residential care. In addition, children in localities with a UM/UR staff person spend less time in residential care, resulting in an average savings of \$3,000 per child in these communities. Further, localities reported that having a local staff person dedicated to UM/UR has improved the quality of services provided to CSA children by giving localities the "eyes and ears" to monitor service delivery more closely.

Despite the potential financial and service delivery benefits that could be generated by hiring a CSA coordinator or UM/UR staff person, only one-third of local programs reported having a full-time coordinator position, and one-quarter of survey respondents indicated being unable to effectively conduct UM/UR given the size of their administrative budgets.

State funding accounts for 20 percent of all local CSA administrative costs. The State's contribution to local administrative funding has been capped at approximately \$38,000 since 2000, despite increasing caseloads and additional demands that have been placed upon local programs by the State. Furthermore, the size of each locality's administrative funding allocation remains based upon their 1997 expenditures and may not reflect the current demands placed on their local programs. As a result, most programs primarily rely on local government funding to subsidize program administration costs. Localities contributed, on average, an additional \$56,000 over and above the required local match in FY 2006 compared to an average State share of \$14,611.

Reliance upon local-only funding to finance program administration has resulted in very disparate and sometimes ad hoc approaches to local program administration. In addition, local governments that have chosen to fund the unmet administrative needs of the program may not always be able to do so. To ensure that all localities are able to hire staff to adequately oversee the CSA program on behalf of their locality and the State, this report contains recommendations to

- increase the State's allocation to enable each locality to employ a CSA coordinator and not rely on discretionary local funding to do so, and
- allocate additional funding to allow local programs to hire their own UM/UR staff, or expand the scope of UM/UR conducted by OCS.

MORE EFFICIENT USE OF LOCAL RESOURCES COULD IMPROVE PROGRAM EFFECTIVENESS

Refocusing the responsibilities of local Family Assessment and Planning Teams (FAPTs) and CPMTs could improve the efficiency and effectiveness of the local CSA service planning process. Instead of focusing on strategic matters, many CPMTs report spending the majority of their time reviewing individual cases despite the fact that they seldom adjust service plans and generally trust the recommendations of FAPTs. In addition, whereas most local program staff reported that the FAPT process is a cornerstone of local programs' effectiveness, they also indicated that certain types of cases do not benefit from FAPT review. Therefore, this report includes recommendations for the OCS to

- encourage CPMTs to focus on developing policies and strategies that ensure appropriate and cost-effective service provision for CSA children, and
- assist localities with focusing FAPT members' time and expertise on the most complex and expensive CSA cases.

CPMTs and FAPTs who are able to contribute more substantially to the CSA system appear to better contain program costs. More active CPMTs tend to spend less per child both overall and for children in residential care. Additionally, local programs whose FAPTs contribute more frequently to children's service plans spend approximately \$6,500 less per child in residential care. In addition to these cost containment benefits, more efficient utilization of local staff resources may further ensure that programs have more time to develop the most appropriate service plans for children.

Overview of the Comprehensive Services Act and Regulation of Residential Facilities

In Summary

The Comprehensive Services Act (CSA) established a system of funding and services that aimed to address the needs of troubled children more efficiently and effectively. Currently, four State agencies jointly participate in guiding the program's direction while localities are primarily responsible for administering the program and making service-delivery decisions. State and local funds are pooled across agencies to fund local CSA programs and are supplemented with federal Medicaid and Title IV-E funding. In 2005, the program spent approximately \$350 million in pooled and Medicaid funding to serve more than 16,000 children, some of whom also received services funded by the Title IV-E program. Most CSA participants are children in foster care or special education programs and are mandated recipients through federal law. Following the program's original intent, CSA children should receive services in the least restrictive yet most appropriate setting to address their individual needs. When children's needs are particularly complex, they may be served in residential facilities. Children's residential facilities are subject to interdepartmental standards that establish minimum requirements. Standards are enforced by four regulatory agencies.

House Joint Resolution 60 of the 2006 General Assembly Session (Appendix A) directed staff of the Joint Legislative Audit and Review Commission (JLARC) to evaluate the administration of the Comprehensive Services Act (CSA). This resolution was enacted to address concerns related to rising program costs, and the adequacy of regulations protecting children's safety in residential facilities. The issues included in the study mandate can be categorized into two primary areas: (1) assessing whether children are safe and receive effective residential services, and (2) understanding the factors that impact program spending and how to control these factors. The mandate directs staff to identify additional steps that could be taken by the State and local governments to balance the quality and cost of residential services. In addition to this study, Senate Joint Resolution 96 created a legislative subcommittee to evaluate the cost-effectiveness of the CSA program in 2006 and 2007. The primary research methods used to conduct this assessment included site visits to 17 localities; surveys of CSA coordinators, residential service providers, and case managers of children who have received CSA services; and an assessment of each community's service gaps. In addition, JLARC staff conducted a quantitative analysis of data collected by the Office of Comprehensive Services. More details about these methods are provided in Appendix B and frequently used acronyms are defined in Appendix C.

OVERVIEW OF THE COMPREHENSIVE SERVICES ACT

With the passage of the Comprehensive Services Act for At-Risk Youth and Families in 1992, the General Assembly attempted to create a seamless approach to meeting the needs of children in Virginia with serious emotional and behavioral problems. Prior to the CSA, these children were served by multiple local agencies using eight different funding streams. This decentralized structure was characterized by excessive costs and duplicative service delivery. To address these shortcomings, CSA reshaped the service delivery system to

- authorize communities to make decisions and be accountable for providing services,
- increase interagency collaboration and family involvement in service delivery and management, and
- provide communities flexibility in the use of funds.

Four State Agencies Jointly Participate in Delivering CSA Services to Children

Four State agencies are key participants in the CSA program: the Departments of Social Services (DSS); Education (DOE); Juvenile Justice (DJJ); and Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS). Each agency serves a particular population and works with different local entities in the service delivery planning process (Table 1).

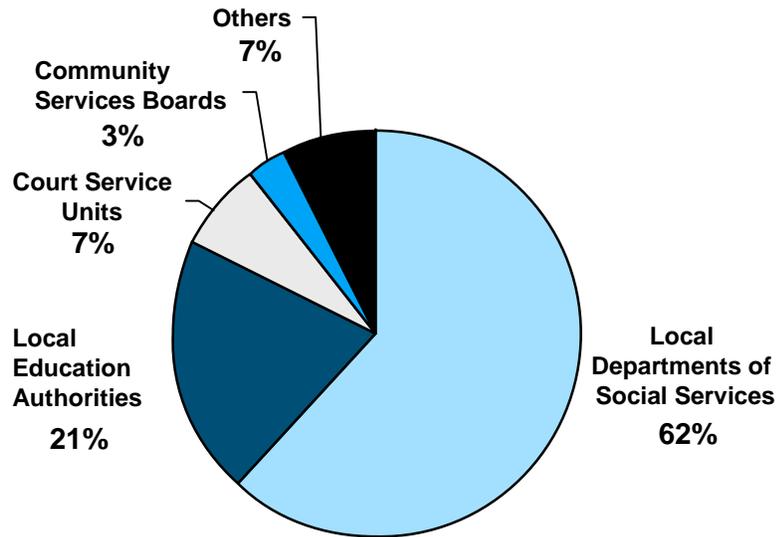
Table 1: State and Local Agency Participants in CSA

State Agency	Children Served	Local Service Delivery System
DMHMRSAS	Children with mental illness	40 community services boards (CSB)
DSS	Foster care children	120 local departments of social services
DJJ	Juvenile offenders	35 court service units
DOE	Special education students	136 school divisions (special education departments) Local education authority

Source: JLARC staff analysis of information published on State agency websites.

Local entities make referrals to the CSA program and participate in the service planning process. Referrals to the local CSA program can come from a variety of sources but typically originate from one of the four local entities. In FY 2006, most referrals were made by DSS case managers (Figure 1). Approximately 20 percent of refer-

Figure 1: CSA Referrals by Local Agency Source (FY 2006)



Source: JLARC staff analysis of data from the Office of Comprehensive Services.

als originated from local school divisions, and the remainder were referred by local court services units, local community services boards (CSBs), or an interagency CSA team.

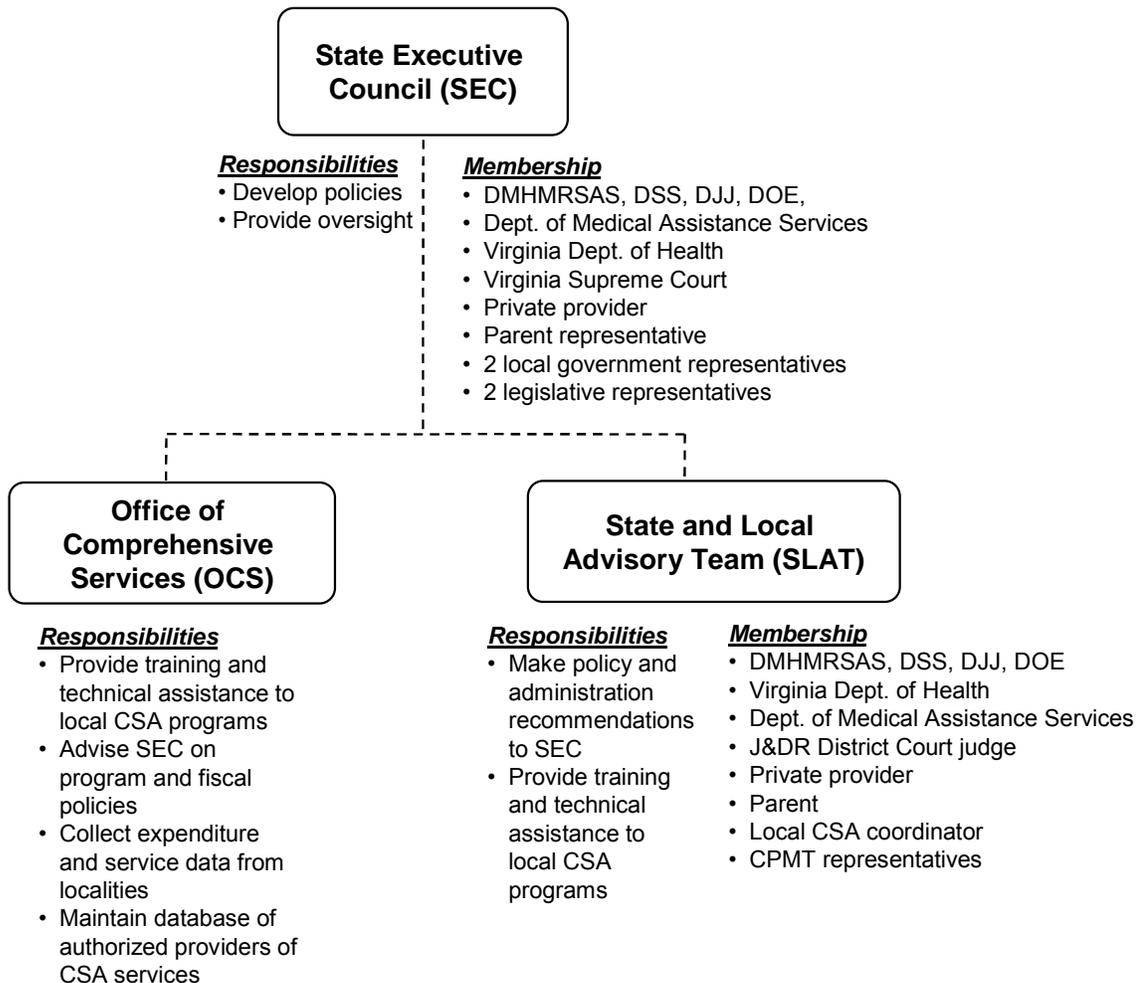
After children begin receiving services through the CSA program, case managers from the referring agency continue to monitor their progress. In addition, local entities participate in cross-agency meetings where comprehensive service plans are designed for each child. Depending upon the locality, agency staff can be assigned to CSA service planning full-time while others also have case management duties within their agency.

Localities Are Primarily Responsible for the Administration of the CSA Program

The passage of the CSA placed greater responsibilities and accountability for serving at-risk children with localities. The State's responsibilities were refocused on developing policies and providing high-level guidance on local program administration. The greatest responsibility for administering the program fell to local agency staff who were tasked with developing detailed local policies and procedures, exercising authority over program expenditures, determining eligibility for services, and developing comprehensive service plans for troubled children.

State Entities Guide the CSA Program. The CSA is administered by three State entities whose membership reflects the General Assembly's intent to promote collaboration across agencies (Figure 2). At the highest level, the State Executive Council (SEC) acts as the supervisory board of the CSA. The State and Local Advisory Team (SLAT) serves as an advisory body to the SEC; its members, who are appointed by the SEC, are expected to act as a collaborative forum for State and local CSA stakeholders, such as CSA staff, parents, and providers, to regularly discuss the program's administration and advise the SEC on any issues that might arise. Whereas the SEC meets quarterly, the SLAT meets monthly. The Office of Comprehensive Services for At-Risk Youth and Families (OCS) is the CSA's administrative body. OCS, which has 13 positions and an administrative budget of \$1.95 million (FY 2005), serves both the SEC as well as local program staff.

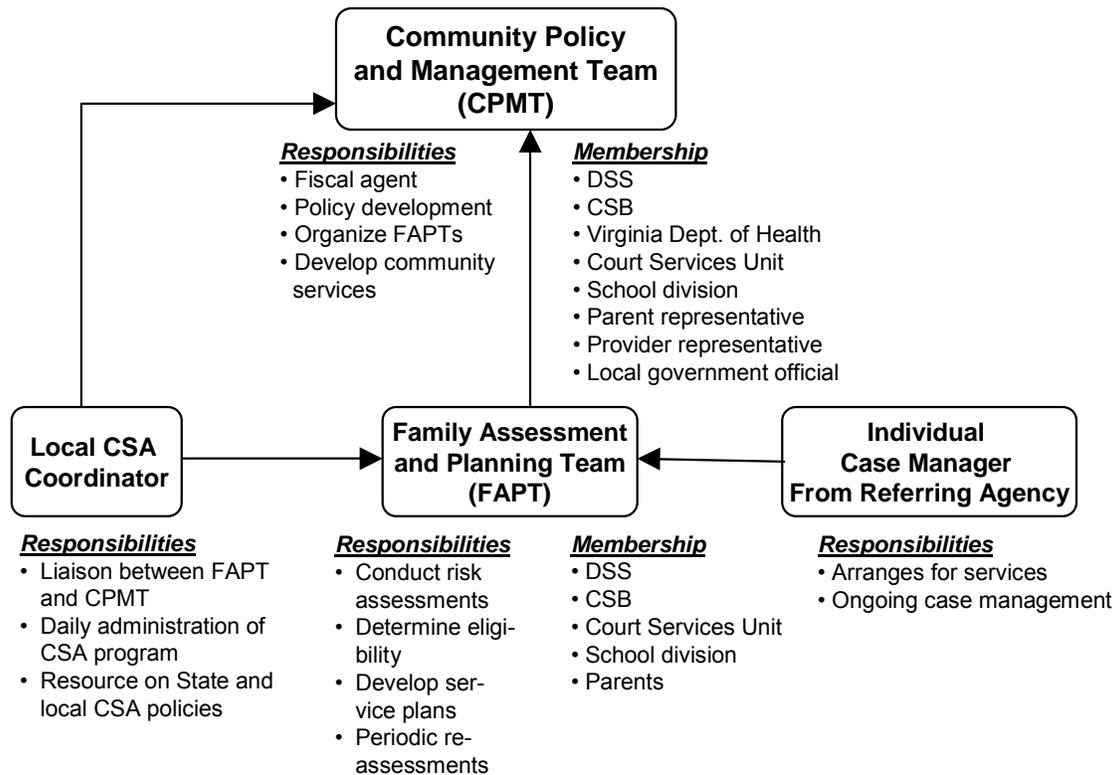
Figure 2: State Management Structure for the CSA



Source: JLARC staff analysis of §§2.2-2648-2649 and §§2.2-5201-5202 of the *Code of Virginia*.

Localities Make Decisions and Facilitate Provision of Services. The *Code of Virginia* mandates a two-tiered structure to manage the CSA at the local level: (1) the Community Policy and Management Team (CPMT), whose role is primarily policy development and fiscal management and (2) the Family Assessment and Planning Team (FAPT), whose role centers on eligibility screening and service planning. Membership structure and general responsibilities of the CPMT and FAPT are shown in Figure 3. In addition, localities may hire a coordinator for their CSA program. Although the State does not specify this position's responsibilities, it appears that CSA coordinators act as a resource on local service availability and State policies pertinent to local program administration, as well as act as the liaison between the CPMT and the FAPT.

Figure 3: Local Management Structure for the CSA



Source: JLARC staff analysis of Title 2.2, Chapter 52 of the *Code of Virginia*.

LOCAL CSA PROGRAMS ARE FUNDED BY MULTIPLE FUNDING STREAMS

CSA funds may be used to purchase public or private services for children and their families. State funding is federally required for "mandated" children who need services. These services are purchased either with State and local funds that were pooled across several agencies when CSA was enacted or through federal programs. In 2005, CSA participants received services totaling nearly \$350 million in pooled and Medicaid funding, as well as other services paid through the Title IV-E program.

Funding Is Tied to Eligibility Categories

The CSA created two broad categories of service eligibility: "mandated" and "non-mandated" children. Children are considered mandated if they are

- in the custody of DSS,
- at risk of being placed in DSS custody (foster care prevention), or
- special education students whose needs cannot be addressed in public classrooms and are therefore eligible for private tuition assistance.

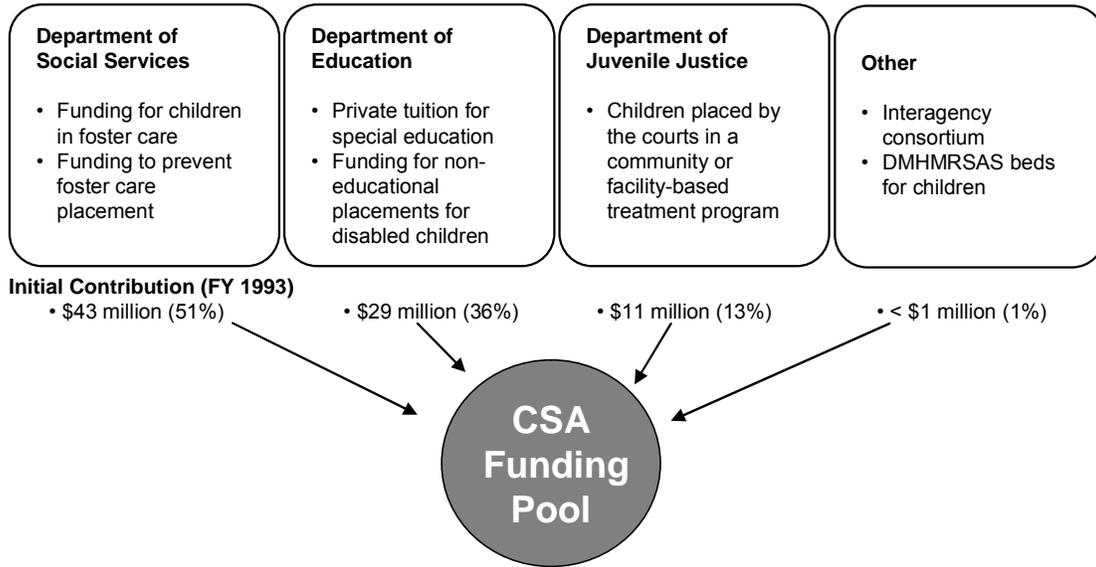
Because federal law mandates that states provide services for children in these categories, funding for mandated children is provided by the General Assembly at a "sum sufficient" level, meaning that additional appropriations are provided by the State when needed. In FY 2005, mandated children received 97 percent of CSA expenditures.

While "non-mandated" CSA children are eligible for services funded by the State pool, local programs are only required to serve them as long as funding is available, and localities may choose not to serve non-mandated children at all. State general funds for non-mandated children are capped, so when a locality expends its funding allocation for children in this category, no additional State funding is appropriated. If CSA funding is not available, these children may receive services from local CSBs or be served by the juvenile justice system.

State and Local Funds Are Pooled Across Agencies

The CSA resulted in the combination of eight previously separate State funding streams into one pool of funds (Figure 4). When the pool was created in FY 1993, DSS contributed roughly half of the pool total, and DOE contributed more than a third. Because the

Figure 4: Funding Categories Combined to Create the CSA State Funding Pool



Source: JLARC staff analysis of §2.2-5211 of the *Code of Virginia*.

pool's intent was to eliminate funding silos, it is no longer possible to calculate the proportion of today's funding that is attributable to a specific agency. Localities are allocated a portion of the State CSA pool based on the greater of either the proportion of its total 1997 pool fund expenditures to 1997 statewide pool fund expenditures or the latest available three-year average of its pool fund expenditures.

Title IV-E Funding

Title IV-E of the Social Security Act provides federal funding to maintain children in foster care and provides subsidies for children adopted from foster care. The Virginia Department of Social Services administers Title IV-E eligibility and works with local departments of social services to administer disbursements in compliance with regulations.

All localities are required to appropriate a local match for their State allocation. The local match rate is based on local 1997 program expenditures and averaged 37 percent in FY 2005, ranging from a minimum of 17 percent (Lunenburg County) to a high of 53 percent (Alexandria City).

Federal Funding Supplements the CSA Pool

Medicaid and Title IV-E funds can be used to supplement State and local CSA funding. Unlike the CSA pool, which is funded entirely with State and local dollars, half of these expenditures are paid with federal funding. Not all children who receive services funded through the Title IV-E program are eligible for CSA pooled funding, but their exact number is unknown. Table 2 compares the share of funding for which each level of government is responsible.

Table 2: Share of CSA Funding (FY 2005)

Funding Source	FY 2005 Expenditures (millions)	Share of Funding			Screening Rate	Enrollment Rate
		Federal	State	Local		
CSA Pool	\$ 273.2	---	63%	37%	n/a	n/a
Medicaid	76.1	50%	32%	18%	73%	65%
Title IV-E	67.1	50%	50%	---	59%	20%

Note: Medicaid and Title IV-E expenditures are on cash basis.

Source: 2005 CSA Biennial Report and 2006 Department of Social Services Annual Statistical Report.

In response to a 1998 JLARC report entitled "Review of the Comprehensive Services Act," the 1998 Appropriations Act directed the Department of Medical Assistance Services (DMAS) to broaden its list of covered services to include (1) case management expenditures for children receiving treatment foster care and (2) residential care in its State Plan for Medical Assistance. This step enabled the State to access federal matching funds. In FY 2005, 73 percent of all CSA children were screened for Medicaid eligibility. Although not all children need to be formally screened for Medicaid eligibility, CSA stakeholders have indicated that some localities may not be maximizing the availability of Medicaid funding.

Local CSA programs can also use Title IV-E funding for foster care services as another federal resource for CSA children. Title IV-E is a federal entitlement program for children placed in State custody and is used to assist with the costs of maintaining children in foster care. As with Medicaid, this federal resource may not be fully utilized; localities screened only 59 percent of CSA children for Title IV-E eligibility in FY 2005, whereas 73 percent of participants were in or at risk for foster care.

PROFILE OF CSA PARTICIPANTS

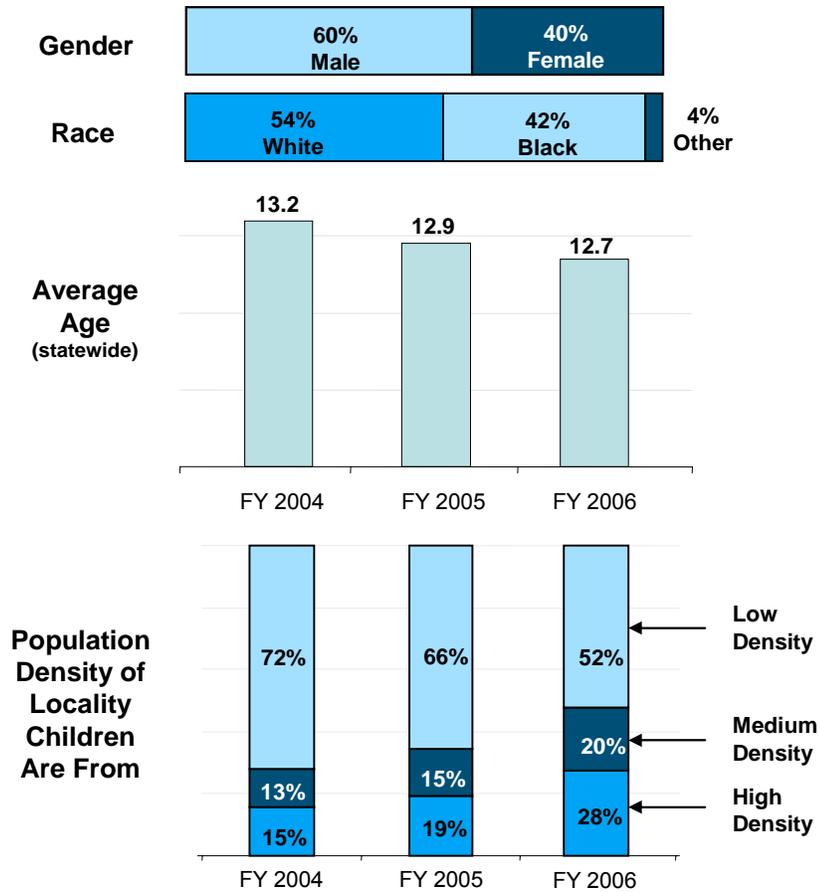
In 2005, the CSA program served 16,272 children. Most CSA participants are children in foster care or special education programs and are mandated recipients through federal law. CSA participants most frequently need CSA services because they experience emotional, mental health, behavioral, or substance abuse issues that are too severe for their caregiver to address.

Who Are the Children Served by the CSA Program?

The typical CSA participant has consistently been a white male over the last three years. During the same period, the average age

of children who receive CSA services has been decreasing and now averages slightly below 13 years (Figure 5). Children who receive residential services tend to be two years older, on average. More children from rural areas are receiving CSA services although this percentage has decreased over the last three years.

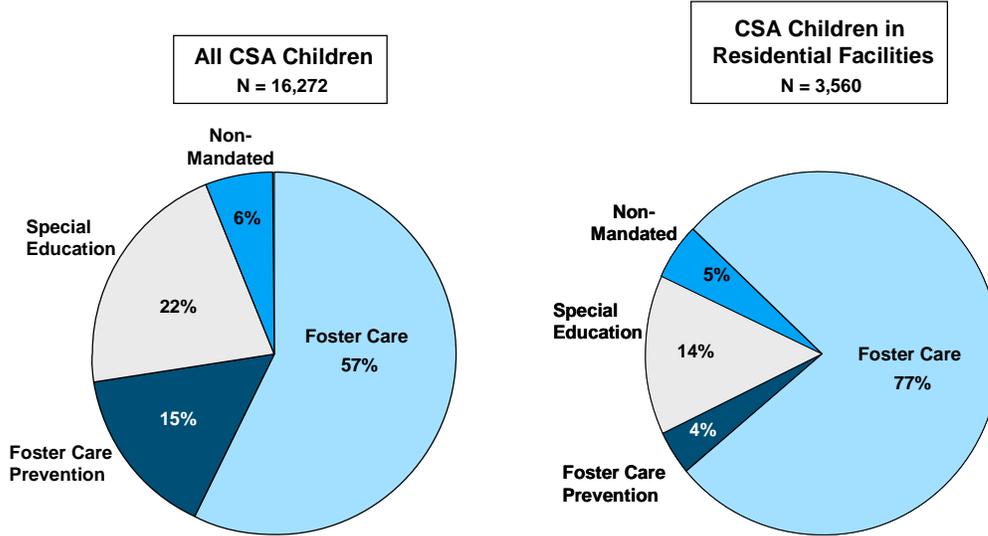
Figure 5: Demographic Characteristics of CSA Children



Source: JLARC staff analysis of data from the Office of Comprehensive Services.

More than half of CSA children served in FY 2006 were eligible for CSA-funded services because they were in the custody of the State, otherwise referred to as foster care (Figure 6). Another 15 percent were at risk of being placed in State custody, and 22 percent were eligible under special education. Only six percent of children served through CSA were outside of these three mandated categories and are therefore considered "non-mandated." Since FY 2004, the proportion of CSA children in each of these mandated categories has remained relatively stable although the proportion of spe-

Figure 6: Percent of CSA Children by Mandate Type (FY 2006)



Source: JLARC staff analysis of data from the Office of Comprehensive Services.

cial education students has increased slightly. The distribution of eligibility categories is different for children who receive residential care. More than three-quarters of these youths are in the State's custody, while far fewer are eligible due to special education or foster care prevention needs, compared to all CSA participants.

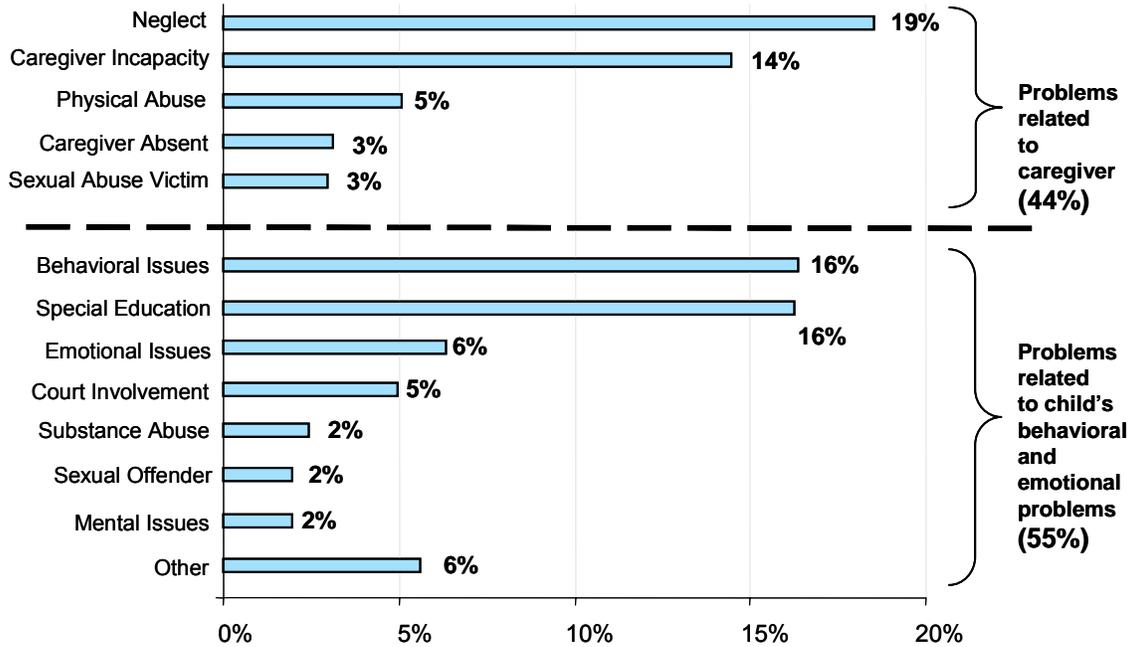
Why Do Children Need to Participate in the CSA Program?

A variety of problems lead children to receive services through the CSA program (Figure 7). Many children require services because they have been mistreated or neglected by their caregiver. However, most children receive CSA services because of their behavior or emotional needs, which range from truancy to self-mutilation to homicidal tendencies. Sometimes these behavioral and emotional problems are indirectly related to caregivers. More than 40 percent of all children in CSA were diagnosed with a mental health problem in FY 2006, and one-third took psychotropic medications.

What Services Do Children Receive Through the CSA Program?

CSA children are supposed to receive services in the least restrictive yet most appropriate setting to address their individual needs, which was the program's original intent. A broad array of services is provided to children in community or residential settings. De-

Figure 7: Primary Reasons for Receiving CSA Services (FY 2006)



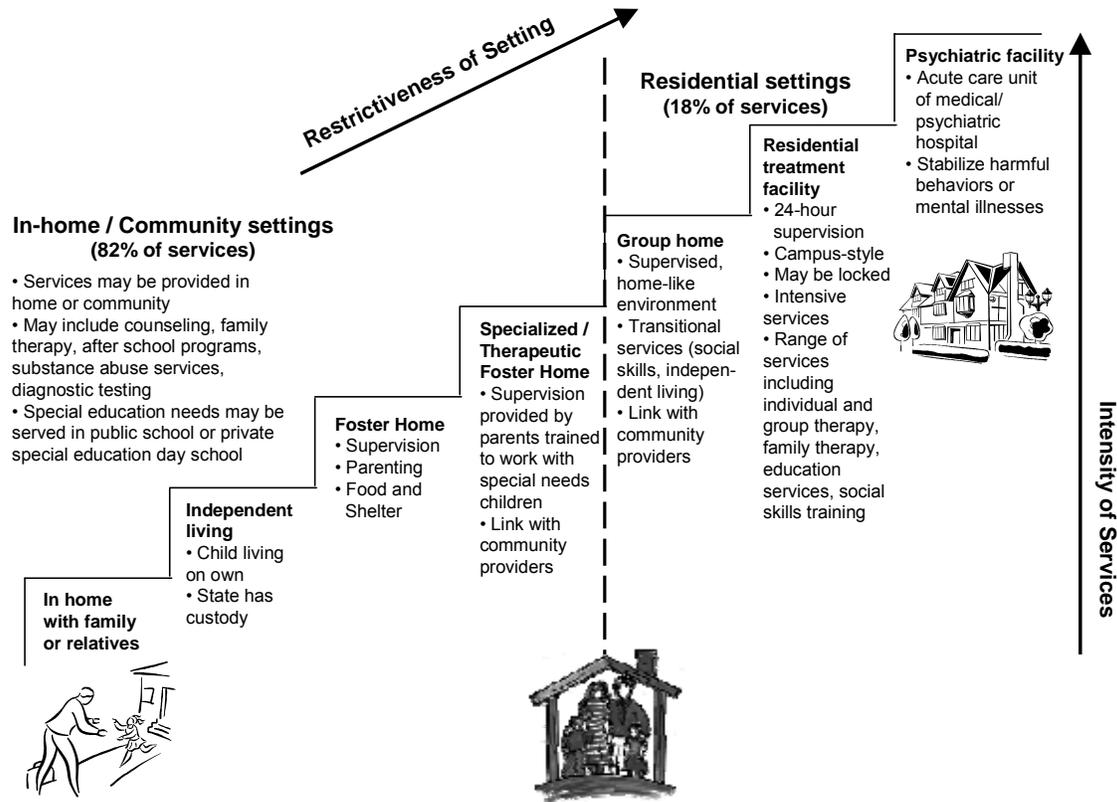
Source: JLARC staff analysis of data from the Office of Comprehensive Services.

pending on the severity of their problems, children may require more or less intensive services on the continuum of care.

CSA Philosophy. The focus of CSA is to serve children in the least restrictive settings, such as their home or community. While the CSA system is "family-focused," it is not always possible or appropriate for children to reside with their families or relatives. Foster care and independent living (for children age 16 years or older) are community-based options for children in these situations. However, children's needs cannot always be adequately addressed in the community. In these situations, children may be placed in residential facilities, which are more restrictive settings designed to serve children with more intense service needs. (In the context of this JLARC study, residential facilities include group homes, residential treatment facilities, and inpatient psychiatric hospitals.) As settings become more restrictive, the services provided also tend to be more intensive and comprehensive and generally more costly to provide.

Continuum of Care. As children no longer need intensive services, they may "step down" into a less restrictive setting. Conversely, if children require more intensive services than they are currently receiving, they may "step up" into a more restrictive setting (Figure 8).

Figure 8: Continuum of Care From Least Restrictive to Most Restrictive Settings



Source: 2005 CSA Biennial Report and OCS definitions for CSA child-level dataset.

The following examples illustrate the complex problems of CSA children and the sometimes successful outcomes of these children.

Case Studies

A 17-year-old male participated in the CSA program for more than three years. He was initially referred to CSA to address his emotional and behavioral issues including physical aggression and sexually inappropriate behaviors. Prior to his referral, he had received in-home mental health services, day treatment, and residential respite care (temporary placement to relieve parents and prevent maltreatment). In addition, he was diagnosed with extreme obesity. Because of his poor health combined with cognitive and behavioral issues, his case manager requested that he be placed in a residential hospital setting with a specialized weight-loss program. Instead, the FAPT and CPMT recommended community-based services, arguing that the com-

munity should try to serve him with less restrictive services before pursuing a residential hospitalization. Over time, he showed improvement in all areas (physical, emotional, behavioral, and academic) and eventually transitioned back into the public school system while continuing to receive mentoring and other supportive community services. Recently, he was discharged from the CSA program and is currently employed, has lost weight, is attending public school, and plans to attend college.

* * *

A 20-year-old male has been in the CSA program for the past six years. As a second grader, he was identified as a special education student with emotional problems and learning disabilities. By the age of 14, he could no longer be served in public school special education programs and was placed in a private day program because of his severe verbal and physical aggression, impaired social skills, and other behavioral problems. At the age of 15, he started setting fires and was charged with two felony sexual assaults. Two years later, he disclosed that he was sexually abused for several years by his mother, who was later incarcerated. Subsequently, the youth was placed in foster care because he had no other relatives to care for him.

Because of his history of aggression and inappropriate sexual behavior, a placement in the community was not feasible, and he was placed in a residential facility for treatment of his sexual abuse and offending behavior. After nearly three years of residential treatment, his aggression has decreased and his behavior is better controlled. Even though he continues to experience some behavioral and interpersonal issues, a step-down program was sought to prepare him for independence as he approaches his 21st birthday, at which point he will age out of the foster care system.

Categorization of Residential Facilities

Facility types were self-reported by providers. If facility type was missing, facilities with a capacity of 12 or fewer residents were categorized as group homes, and larger facilities were categorized as residential treatment facilities.

PROFILE OF CHILDREN'S RESIDENTIAL FACILITIES

Currently, there are almost 300 licensed children's residential facilities in Virginia, and nearly all of them serve children with behavioral disorders or emotional issues. Further, the number of facilities has increased substantially since CSA began in 1992. While the vast majority of residential facilities are privately owned, some are operated by the State or local governments.

Majority of Facilities Are Considered "Group Homes"

Several types of children's residential facilities serve children with different needs or at varying levels of intensity. Of the facilities that responded to a JLARC staff survey of residential service providers, the majority are group homes, which tend to be smaller than other facilities (average size of 13 occupants) (Table 3). An additional 21 percent of facilities are residential treatment facilities, which tend to be larger than group homes, on average. Further, group homes and residential treatment facilities in Virginia are occupied at about 75 percent capacity, on average (Table 3). Only five percent of responding providers are intensive residential treatment facilities, which is the most restrictive setting. There are few wilderness and diagnostic programs in the State, and those programs are mostly full.

Residential Facilities Serve Children With Varying Needs

Residential facilities serve children with a wide spectrum of problems that necessitate the need for that level of service (Figure 9).

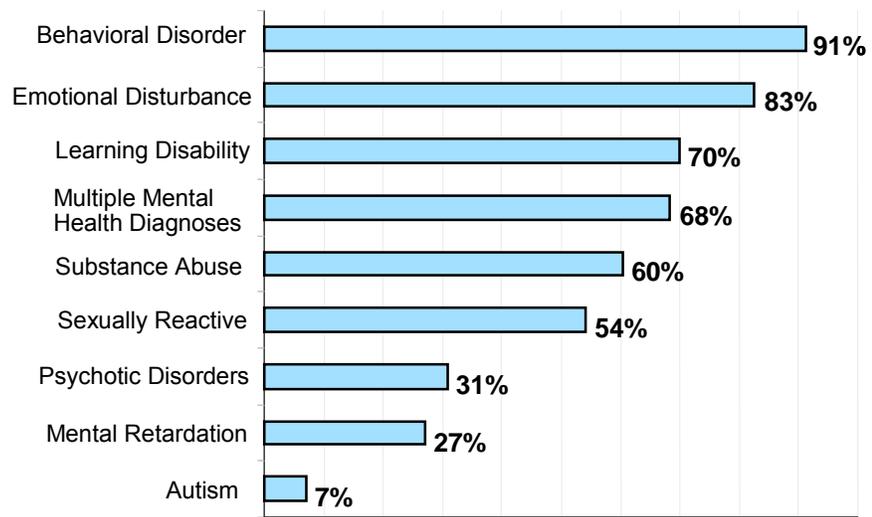
Table 3: Types of Children's Facilities in Virginia (2006)

Facility Type	Description	Percent	Average Size	Average Percent Occupancy*	N
Group Home	Supervised homelike environment that serves groups of 12 or fewer youths with behavioral or emotional difficulties and/or physical or mental disabilities.	64%	13	79%	79
Residential Treatment	Facilities that serve more than 12 residents and offer 24-hour intensive treatment rather than just supervision. Intensive treatment services include medication management, special and regular education services, and youth and family therapy.	21%	44	73%	26
Emergency Shelter	Temporary placement of a child because of or to prevent maltreatment.	6%	13	70%	7
Intensive Residential Treatment	Facilities that provide services whose intensity falls between that of residential treatment facilities and inpatient psychiatric hospitals.	5%	50	74%	6
Wilderness Program	Residential group care in which youth and staff live together in a wilderness environment.	2%	42	96%	3
Diagnostic	Facilities that conduct 30- to 60-day evaluations of individuals' social, emotional, behavioral, educational, and medical needs. The evaluations may also identify services needed to address the child's needs.	2%	30	91%	3
TOTAL		100%			124

* Average percent occupancy was calculated at one point in time.

Source: JLARC staff survey of residential service providers, 2006.

Figure 9: Most Residential Facilities Serve Children With Behavioral or Emotional Problems



Source: JLARC staff survey of residential service providers, 2006.

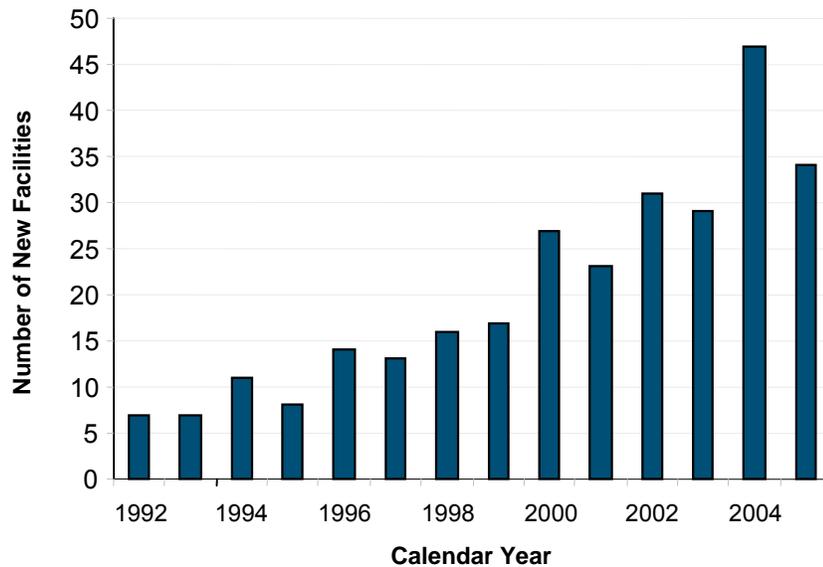
Nearly all residential facilities in Virginia serve children with behavioral disorders, such as oppositional defiance, aggression, or impulse control. The majority of facilities also serve children with emotional issues, such as anxiety, eating, or mood disorders. A smaller number of facilities serve children who are mentally retarded, suffer from psychiatric disorders, such as schizophrenia, or are autistic.

Number of Children's Residential Facilities Has Increased Since CSA Began

Between January 1992 and January 2006, the number of licensed children's residential facilities increased by more than 80 percent. The largest increase in new facilities was in 2004, when 49 new facilities opened (Figure 10). Of the facilities that opened between April 2001 and March 2006, 17 percent opened in Henrico and Chesterfield counties, 12 percent opened in Richmond City, and eight percent opened in Norfolk. According to results of a JLARC survey of residential providers and licensing data provided by OIR, the majority of the new facilities that opened were group homes (62 percent). In addition, 75 percent of facilities that opened since April 2001 identified themselves as for-profit, compared to 16 percent of facilities that have been operating for more than five years.

Seventy-five percent of facilities that opened since April 2001 identified themselves as for-profit, compared to 16 percent of facilities that have been operating for more than five years.

Figure 10: Number of New Residential Facilities Has Increased Since 1992



Note: Number of open facilities as of January 1 of each year.

Source: Office of Interdepartmental Regulation.

LICENSING SYSTEM

Most children's residential facilities in Virginia are regulated under the Interdepartmental Regulation Program. This program was created in response to a 1977 report by the Subcommittee on the Placement of Children, which characterized licensing efforts as uncoordinated and duplicative across four State agencies: Department of Social Services (DSS), Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS), Department of Juvenile Justice (DJJ), and Department of Education (DOE). In response, these four agencies pledged to cooperate in the development of an interdepartmental regulatory program. Since then, they have retained separate licensing responsibilities but have cooperated in developing a common set of standards to govern the regulation of children's residential facilities. As of March 2006, these four agencies regulated 291 facilities. In addition, the Office of Interdepartmental Regulation (OIR) was established within DSS to coordinate regulatory activities, including assigning licensure activities to the appropriate agencies.

Office of Interdepartmental Regulation Coordinates Activities and Assigns Lead Agencies

OIR coordinates regulatory and licensure activities conducted by the four State agencies and facilitates the development of interde-

partmental standards. In addition, it conducts training for regulatory personnel and providers of children's residential services on a variety of topics. OIR also processes background investigations for all employees, volunteers, and contract service providers of facilities licensed by the regulatory agencies. The office regularly receives advice on this process from three committees (Table 4).

Table 4: Interdepartmental Regulation Committees

Committee	Composition
Coordinating Committee	One representative from each licensing agency at the commissioner level.
Liaison Committee	One representative from each licensing agency at the licensing management level.
Advisory Committee	Members of the service provider community and State staff including a CSA representative.

Source: Office of Interdepartmental Regulation.

OIR does not conduct licensing inspections to residential facilities. Instead, it assigns a lead regulatory agency to each facility based on the primary focus of the residential program, the services provided, the qualifications of facility staff, and the population served. Multiple agencies may have regulatory authority over a facility if the facility has more than one focus. For example, residential facilities that treat children with a mental illness and also provide educational services may be licensed by DMHMRSAS, with DOE assigned as the secondary licensor.

Four State Agencies License and Monitor Compliance in Children's Residential Facilities

Lead agencies are responsible for facilitating licensing inspections and issuing licenses for the facilities they regulate. DMHMRSAS serves as the lead agency for nearly 40 percent of the 291 facilities licensed by the State, and DSS for another 30 percent. Table 5 shows the number and type of facilities regulated by each agency.

Agency staff inspect facilities and monitor compliance with State regulations. The lead agency issues conditional, annual, triennial, or provisional licenses to facilities based on their level of compliance with regulations as well as their length of operation (Table 6). Most facilities have triennial licenses, which indicate the highest level of compliance (Figure 11). As of March 31, 2006, less than one percent of facilities had provisional licenses, which are issued to facilities that are not in substantial compliance with State regulations and have two systemic deficiencies. A systemic deficiency refers to a violation that may affect the entire operation or major component of a program.

Table 5: Lead Agencies License Facilities With Different Programs (as of 3/31/06)

Lead Agency	Number of Licensed Facilities	Examples of Licensed Facilities	Program Descriptions
DMHMRSAS	111	<ul style="list-style-type: none"> • State hospitals • Residential treatment facilities • Group homes 	Specialized treatment and services for children with mental illness, mental retardation, or substance abuse
DSS	86	<ul style="list-style-type: none"> • Group homes • Residential facilities • Mother-baby programs • Independent living programs 	Programs providing full-time care, maintenance, protection, and guidance to children
DJJ	63	<ul style="list-style-type: none"> • Juvenile correctional facilities • Group homes • Secure detention homes • Contracted residential facilities 	Juvenile justice programs
DOE	31	<ul style="list-style-type: none"> • Group homes • Residential facilities • Schools for deaf & blind 	Private educational programs for students with disabilities
Total	291		

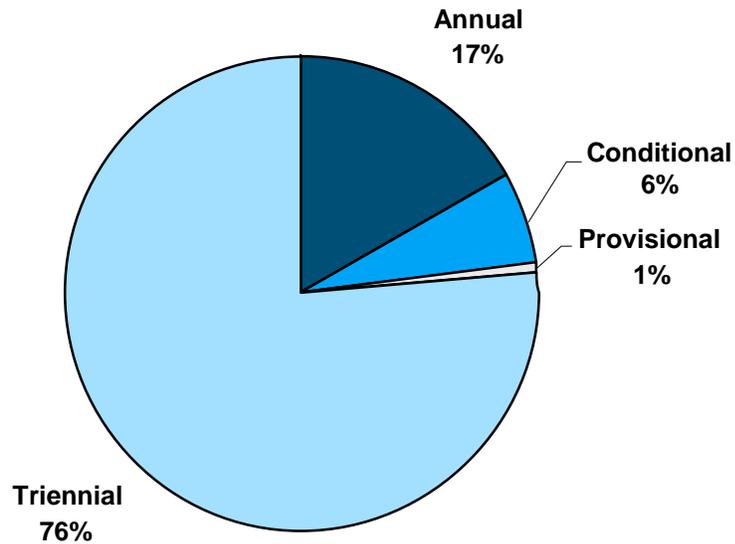
Source: Office of Interdepartmental Regulation and Department of Juvenile Justice.

Table 6: Types of Licenses for Residential Facilities

License Type	Description
Conditional	Typically issued to new facilities for the first six months; they must demonstrate progress toward compliance during that time.
Annual	Typically issued to facilities after a conditional license or to facilities that have an uncorrected systemic deficiency.
Triennial	Highest license a facility can receive; issued to facilities in substantial compliance with the standards with no uncorrected systemic deficiencies.
Provisional	Issued to facilities that are not in substantial compliance with the standards or have 2 uncorrected systemic deficiencies; they must improve or they will lose their license; not to exceed 6 months.

Source: Office of Interdepartmental Regulation.

Figure 11: License Types of Open Facilities on March 31, 2006



Source: JLARC staff analysis of licensing data from the Office of Interdepartmental Regulation.

Licensing staff assess compliance with State regulations by conducting inspections of residential facilities for which they are the lead agency. Initial inspections are made before new applicants are issued a license to operate residential facilities. Subsequent announced and unannounced inspections are made to monitor ongoing compliance. In addition, regulatory agencies also investigate complaints made about a facility. Table 7 summarizes the types of inspections conducted by licensing agencies, as well as activities conducted during these inspections.

Table 7: Types of Inspections Conducted by Lead Licensing Agencies

Type of Inspection	Description / Frequency of Inspection	Activities Conducted During Inspections
Initial	Once at application	<ul style="list-style-type: none"> • Review of resident and personnel records, serious incident reports, and medication logs • Interviews with residents and staff • Inspection of the facility's physical environment
Unannounced	Completed once a year	
Announced	Conducted annually (DJJ and DSS) or when license is up for renewal (after six months, one year, or three years)	
Complaint	Investigation of complaints as reported	

Note: Facilities regulated by DSS and DJJ must be inspected at least twice a year.

Source: Office of Interdepartmental Regulation.

REGULATORY STANDARDS

As a part of the interdepartmental program, the four State agencies and representatives of residential facilities developed a common set of regulations for residential programs. The interdepartmental standards first became effective July 1, 1981, and have been amended a number of times, most recently in July 2000.

These standards establish a minimum level of regulation necessary to ensure protection and treatment of children receiving residential services. In addition, all agencies except for DSS impose supplementary requirements upon the facilities which they regulate.

Interdepartmental Standards Establish a Minimum Level of Regulation for Residential Facilities

The interdepartmental standards address several broad areas related to the operation of children's residential facilities, including the terms of licensure, administration of the facility, residential environment, programs and services, and disaster or emergency planning. Prior to initial licensure, and during subsequent inspections, agency staff assess compliance of residential facilities with the interdepartmental standards. Table 8 summarizes several key components of these standards.

New Legislation Requires Additional Regulations

The 2006 Session of the General Assembly passed legislation directing the four licensing agencies to promulgate additional interdepartmental regulations regarding initial licensure of residential programs. Specifically, House Bill 577 requires applicants to

- be personally interviewed by department personnel to determine qualifications;
- provide evidence of having relevant prior experience;
- provide evidence of staff participation in training on appropriate siting of residential facilities for children, good neighbor policies, and community relations; and
- screen residents prior to admission to exclude individuals with behavioral issues that cannot be managed in the facility.

Furthermore, lead agencies must notify local governments and placing and funding agencies, including OCS, when a facility's licensure status is changed to provisional. House Bill 577 also

Table 8: Summary of Key Interdepartmental Standards

Area	Description of Facility Standards
Administration	
Staff Development	<ul style="list-style-type: none"> • New employees must receive orientation within a month • Personnel must receive documented training and regular supervision
Staff Qualifications	Outlines minimum educational degrees and work experience for key positions: chief administrative officer / executive director, program director, direct care supervisors and staff
Admission Procedures	Facilities must have written admission criteria and can only accept children they can properly serve
Environment	
Buildings and Grounds	Must be safe, clean, and properly maintained
Programs and Services	
Service Planning	Must develop individualized service plans to address resident goals and objectives
Social Services (Case Management)	<p>Must be available to help residents</p> <ul style="list-style-type: none"> • maintain relationships with family, • utilize community resources, • strengthen their capacity for interpersonal relationships, and • plan for the future
Structured Program of Care	<p>Must offer a daily living program that</p> <ul style="list-style-type: none"> • provides protection, guidance and supervision to residents, and • meets the objectives of residents' service plans
Health Care / Medical Training	Must have written procedures for providing or arranging for the provision of medical and dental services for health problems identified at admission, as well as routine and follow-up services after admission
Medical Exams and Treatment	Must ensure that residents' physical needs are identified, monitored, and met
Medication	Medication must be properly prescribed, administered, and monitored
Nutrition	Must provide residents three nutritionally balanced meals and an evening snack that meet minimum nutritional requirements and the U.S. Dietary Guidelines
Staffing Supervision (ratios)	Must meet minimum ratios of direct care staff to residents
Behavior Management	Must help children achieve positive behaviors and address inappropriate behaviors in a safe manner according to written policies
Physical Restraint	<ul style="list-style-type: none"> • Prevents facilities from unwarranted use of physical restraint • Requires staff to be trained in proper techniques
Emergency Reports	Document serious injuries and incidents and report them to the placing agency and legal guardian

Source: JLARC staff analysis of 22 VAC 42.

permits licensing agencies to "modify the term of the license at anytime during the term of the license based on a change in compliance." Prior to this legislation, regulatory agencies could not change the status of a license to provisional until the term of the existing license expired, which could be up to three years.

Licensing Agencies Also Regulate Residential Facilities Through Additional Modules

In addition to interdepartmental standards, three agencies independently promulgated supplemental regulations governing specialized treatment components of the programs they license:

- DMHMRSAS regulations address clinical treatment, training and rehabilitation services, behavioral management, and medication administration. In addition, human rights regulations assure the protection of the rights of consumers in all facilities and programs operated, funded, or licensed by DMHMRSAS.
- DOE regulations address the education programs, including special education and related services.
- DJJ regulations address program operations, health care, personnel, facility safety, and physical environment of residential facilities in the Commonwealth's juvenile justice system. They set additional standards for secure custody facilities, work camps, juvenile industries, and independent living programs.

When an agency serves as the secondary licensor (or regulatory authority) for a facility, it monitors compliance of the facility with its module.

Medicaid-Certified Residential Facilities Are Required to Meet Additional Regulations

Children's residential facilities (group homes, residential treatment facilities, and psychiatric facilities) must meet additional standards to receive Medicaid reimbursement for services. In order to receive this reimbursement, these facilities must be certified by the Virginia Department of Medical Assistance Services (DMAS). As shown in Table 9, facilities seeking Medicaid certification must first be licensed as children's residential facilities and also meet higher staff qualifications and staffing ratios than are required under the interdepartmental standards. Additionally, residential and psychiatric facilities must be accredited by organizations approved by DMAS in order to receive certification.

Table 9: Medicaid Certification Requires Residential Facilities to Meet Additional Standards

Facility Characteristics	Licensing Agency	Staff Qualifications	Staff Ratio
Level A Group Home	DSS DJJ DOE	Program director <ul style="list-style-type: none"> • Qualified mental health professional¹ • Bachelor's degree • Full-time • 1 year field work in mental health 	1:6 daytime 1:10 nighttime
Level B Group Home	DMHMRSAS	Program director <ul style="list-style-type: none"> • Bachelor's degree • 1 year clinical experience Clinical director: <ul style="list-style-type: none"> • Licensed mental health professional² • Caseload not to exceed 16 children 	1:4 daytime 1:8 nighttime
Level C Residential Treatment Facilities	DMHMRSAS	Psychiatrists, psychologists, licensed clinical social workers, licensed professional counselors, clinical nurse specialists	Not specified

¹Physician, psychiatrist, psychologist, social workers, or registered nurses with clinical experience.

²Physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, or clinical nurse specialist.

Source: Department of Medical Assistance Services provider manuals.

Regulatory Environment Appears Inadequate to Ensure Children’s Health and Safety

In Summary

The State’s process for licensing and enforcing compliance of residential facilities does not appear to adequately support children’s basic health and safety. Current licensing standards are not adequately enforced, as regulatory agencies miss required inspections and spend less time conducting inspections than they think is necessary. Formal actions also do not appear to be consistently taken against facilities with chronic violation patterns. Greater enforcement resources, clarity, and authority could enable licensing agencies to identify problems before they escalate and better hold providers accountable for safeguarding the health and safety of their residents. However, focusing solely on improving enforcement efforts may not be sufficient to preserve children’s safety in residential facilities. Virginia’s licensing standards fall below those implemented by many neighboring states in areas that are critical to children’s well-being. While many providers have chosen to exceed the State’s minimum standards of their own accord, the current system allows facilities to operate under conditions that do not ensure the health and safety of children. Standards need to be strengthened to ensure that all providers are held to a minimum level of care that could better ensure the safety of children.

A fundamental responsibility of the State and children’s residential facilities is to keep children in their custody safe and healthy. This basic goal must also be met before these children’s emotional and behavioral problems that prompted their need for residential care can be addressed (discussed in Chapter 3). House Joint Resolution 60 was enacted in part due to concerns that Virginia’s regulatory process may be inadequate to ensure the safety of vulnerable children placed in residential facilities. The study mandate directs JLARC staff to evaluate the interdepartmental regulation of these facilities and determine the steps that may be necessary to protect the health, safety, and welfare of children placed in residential facilities.

The fatalities and case examples discussed in this chapter are illustrative and should not be interpreted as representative of the conditions present in all children’s residential facilities in Virginia. However, the incidents described serve as indicators which, along with a strong consensus among licensing staff, Virginia providers’ practices, other states’ requirements, and national recommendations, point to the need for stronger standards and greater enforcement efforts to ensure the health and safety of children in residential facilities. While greater enforcement efforts cannot prevent every incident from occurring and more stringent standards will not guarantee that all children are consistently kept safe,

Research Methods

JLARC staff analyzed licensing data to identify trends in quality and compliance. Staff primarily examined facilities that receive CSA funding. In addition, staff surveyed residential facilities in the State, and 85 percent responded. Appendix C provides a list of non-responders. JLARC staff also interviewed licensing staff and accompanied licensing specialists during inspections of children's residential facilities.

Twenty-seven facilities open for the entire year were not inspected at all by their lead agencies.

these two mechanisms are the State's primary means to minimize incidents that jeopardize the health and safety of children.

INADEQUATE ENFORCEMENT MAY UNDERMINE PROVIDER ACCOUNTABILITY AND COMPROMISE SAFETY

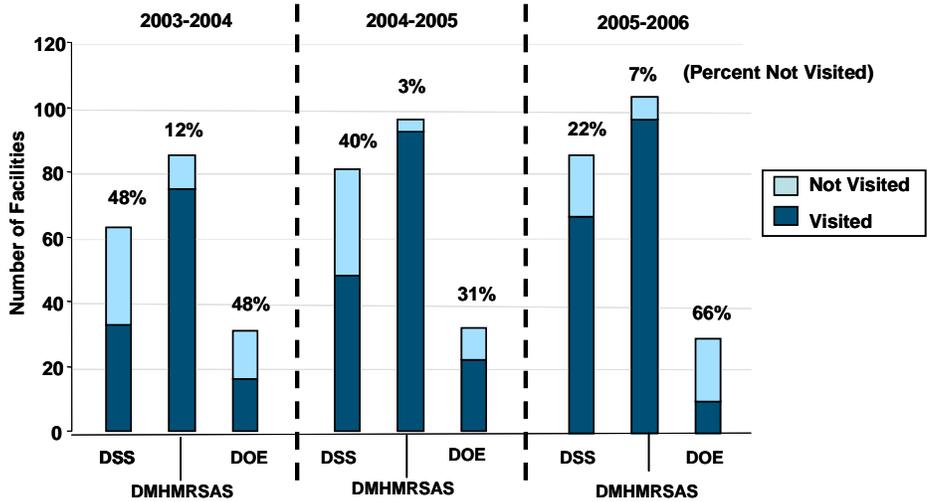
To effectively hold providers accountable for meeting licensure requirements, standards must be properly and consistently enforced by licensing agencies. However, data from licensing agencies as well as interviews with staff suggest that enforcement efforts may not be adequate to ensure child safety. As a result of inadequate enforcement, some children's residential facilities may chronically operate below minimum licensure requirements, thereby threatening the health and safety of residents. To provide greater oversight, licensing agencies may need more resources, clarity, and authority to enforce compliance.

Inspections May Not Be Sufficiently Frequent or Thorough

Agencies do not appear to conduct all inspections required by statute, and they spend less time on an inspection than they think necessary. Because licensing standards are minimum requirements by statute, the inability of agencies to consistently and thoroughly monitor facility compliance with their components could jeopardize the well-being of children. If facilities are not monitored frequently enough by inspectors, problems could become severe and systemic. Moreover, agency staff consistently stated that the required number of inspections is inadequate to monitor even the best providers. If staff cannot spend sufficient time conducting inspections, they may overlook problems or fail to identify them as part of broader operational problems.

Licensing Agencies Do Not Appear to Conduct Required Number of Inspections. Inspections are the primary means to monitor whether facilities are complying with standards, yet licensing agencies are not completing their mandated inspections of children's residential facilities. Each licensing agency is required to conduct one unannounced inspection each year, as well as investigate complaints as they arise. In addition to an unannounced inspection, DSS and DJJ also perform an announced inspection annually. Between April 2005 and March 2006, 21 percent of children's residential facilities licensed by DSS, DOE, and DMHMRSAS were not inspected at the interval required by the *Code of Virginia* (Figure 12). Twenty-seven facilities that were open for that entire year were not inspected at all by their lead agencies. Some facilities had not been inspected for over two years (Table 10). As a result of infrequent inspections, licensing specialists may not detect problems before they escalate.

Figure 12: Some Facilities Are Not Inspected by Their Lead Agency at Required Intervals



Notes: Calculations based on facilities that were continuously open for 12 months (April 1 to March 31) that were not inspected by lead agency. Calculations for DSS based on facilities not inspected twice during the year.

Source: Staff analysis of licensing data from the Office of Interdepartmental Regulation and DMHMRSAS.

Table 10: Some Facilities Have Not Been Inspected in Two Years

Lead Agency	Average Number of Months Between Licensing Inspections		
	Overall	5% of Facilities Least Frequently Inspected	5% of Facilities Most Frequently Inspected
DOE	11	25	4
DSS	7	11	3
DMHMRSAS	6	15	2

Note: These calculations include complaint investigations. Calculations based on all years of data (April 1, 2001 to March 31, 2006 for DOE and DSS, and January 1, 2003 to March 31, 2006 for DMHMRSAS). DSS is required to inspect facilities twice a year.

Source: JLARC staff analysis of licensing data from the Office of Interdepartmental Regulation and DMHMRSAS.

Required Number of Inspections May Not Be Adequate. Licensing specialists report that even if they were able to conduct all mandated inspections, this effort would still be insufficient to monitor providers. This opinion is also shared by many providers. Based on survey results, 69 percent of providers think that more frequent licensing inspections would be at least somewhat effective in improving the overall quality of residential services in Virginia.

By comparison, it should be noted that Virginia requires assisted living facilities (ALF) for adults to be inspected more frequently than children's residential facilities even though children may be more vulnerable (Table 11). Although both types of facilities with triennial licenses are inspected at the same frequency, new children's residential facilities and those with compliance problems are inspected less frequently than ALFs with similar licensure status. For example, ALFs with conditional licenses are inspected twice as frequently at children's residential facilities, and ALFs with provisional licenses are inspected three times as frequently.

Table 11: Assisted Living Facilities (ALFs) Inspected More Frequently Than Children's Residential Facilities

License Type	Length of License	Required Inspections	
		Children's Residential Facilities	ALFs
Provisional	6 months	Once at six months	Once every other month
Conditional	6 months	Once at six months	Twice in first six months
Annual	1 year	Once or twice a year	Three times a year
Triennial	3 years	Once a year	Once a year

Source: JLARC staff analysis of the Office of Interdepartmental Regulation and DSS standard operating procedures for ALFs.

Inspections May Not Be Sufficiently Thorough. There is consensus among licensing specialists that inspections may not be long enough to identify all areas of noncompliance with standards. For example, 86 percent of all inspections are conducted in two days or less, yet licensing staff consistently report that a thorough review cannot be conducted in less than two-and-a-half to three days (Table 12). As a result, licensing specialists may overlook problems which, if left uncorrected, could ultimately harm residents' well-being. One licensing specialist summarized that "there are so many standards to determine on a review that it is difficult to get the big picture, especially in two days. You only get a snapshot and it may depend on the [specific] files reviewed."

The time allocated per inspection varies substantially by licensing agency, which also suggests that the thoroughness of their investigations varies (Table 12). For example, DMHMRSAS licensing specialists complete almost all their inspections in one day or less, and they cite fewer violations per inspection than DSS and DOE (Figure 13). They also cite violations in a smaller proportion of inspections than the other agencies. DMHMRSAS staff indicated that this could also result from their facilities being held to higher

Table 12: Agencies Spend Varying Amounts of Time on Site During Inspections

Lead Agency	One Day or Less	Two Days	More than Two Days
DOE	31%	29%	40%
DSS	43	37	20
DMHMRSAS	95	3	3
Overall	63	23	15

Note: These calculations include only inspections by lead agency and exclude complaint investigations. DJJ information was not available to conduct this analysis.

Source: JLARC staff analysis of licensing data from the Office of Interdepartmental Regulation and DMHMRSAS for the period April 1, 2005 to March 31, 2006.

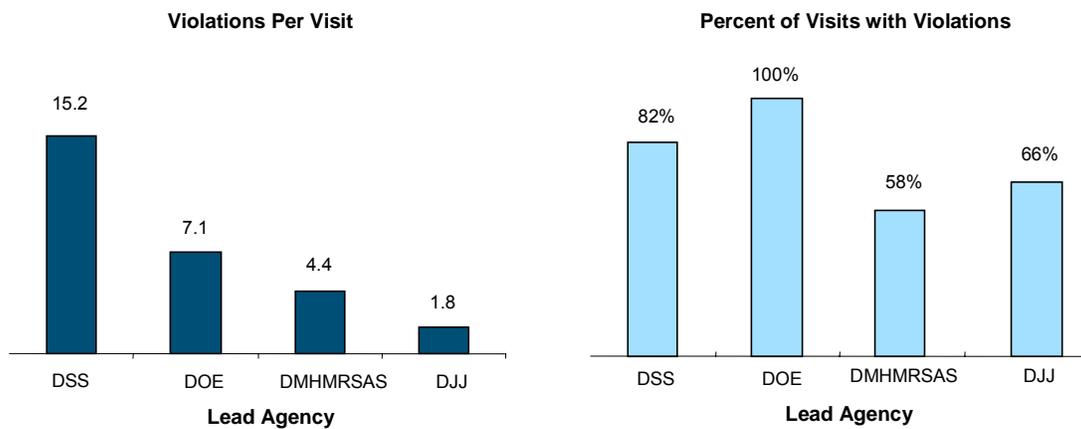
standards through their mental health module, human rights regulations, and Medicaid certification.

Licensing staff report that they have insufficient time to review personnel and resident records. For instance, staff review only one or two resident records during unannounced inspections, which could make it difficult for them to identify patterns of behavior or cite systemic deficiencies, especially in large facilities. Furthermore, limited inspection time makes it difficult for them to assess a facility's compliance with certain standards. For example, regulations require that facilities "shall accept and serve only those children whose needs are compatible with the services provided through the facility," yet staff explained that they may not be able to identify whether a facility is violating that standard if they review only a limited number of resident records. In addition, interviews with staff and residents enable licensing specialists to assess the quality of programs beyond what is documented in records, yet they report having insufficient time to conduct these interviews.

Systemic Deficiency

Documented violations demonstrate defects in overall operation of the facility or one or more of its components. Two or more systemic deficiencies issued within a licensure period results in provisional license status.

Figure 13: Agencies That Spend Less Time Inspecting Facilities May Overlook Violations



Source: JLARC staff analysis of licensing data from the Office of Interdepartmental Regulation and DMHMRSAS for the period April 1, 2005, to March 31, 2006.

Agencies Do Not Appear to Consistently Use Formal Enforcement Actions to Gain Provider Compliance

It appears that licensing agencies do not always take effective enforcement actions against providers. For example, more than half of facilities that repeatedly violated critical standards between 2003 and 2006 had no enforcement action taken against them despite recurring problems. Agencies also appear to use enforcement tools differently, and residential providers almost never lose their licenses, even in cases that fundamentally threaten the health and safety of residents.

More than half of the facilities with repeated violations had no formal enforcement action taken against them.

Some Facilities with High Numbers of Repeat Violations Receive No Formal Enforcement Action. Between 2003 and 2006, more than 100 facilities in Virginia had repeated violations of standards considered by licensing specialists to be critical to ensuring the health and safety of residents (Table 13). While agencies exercised a variety of enforcement approaches to remedy the repeat violations, more than half of the facilities with repeated violations between 2003 and 2006 had no formal enforcement action taken against them.

Table 13: Critical Standards Identified by Licensing Specialists

Structured program of care providing protection, supervision, and guidance to residents
Health care and medication procedures
Staff supervision of children (ratios of staff to children)
Management of resident behavior
Safe, clean, and properly maintained grounds
Reporting of child abuse and neglect and serious incidents and injuries
Qualifications of staff
Clear admission criteria and policies
Case management, therapy, and education services
Service planning

Source: State licensing specialists.

Although agencies may utilize a number of means to gain provider compliance, less formal mechanisms do not always appear to compel providers to remedy deficiencies. In cases when no formal enforcement action is taken, compliance problems are addressed through corrective action plans that providers submit to their licensing agency following inspections with cited violations. These plans indicate how the facility will correct each cited violation.

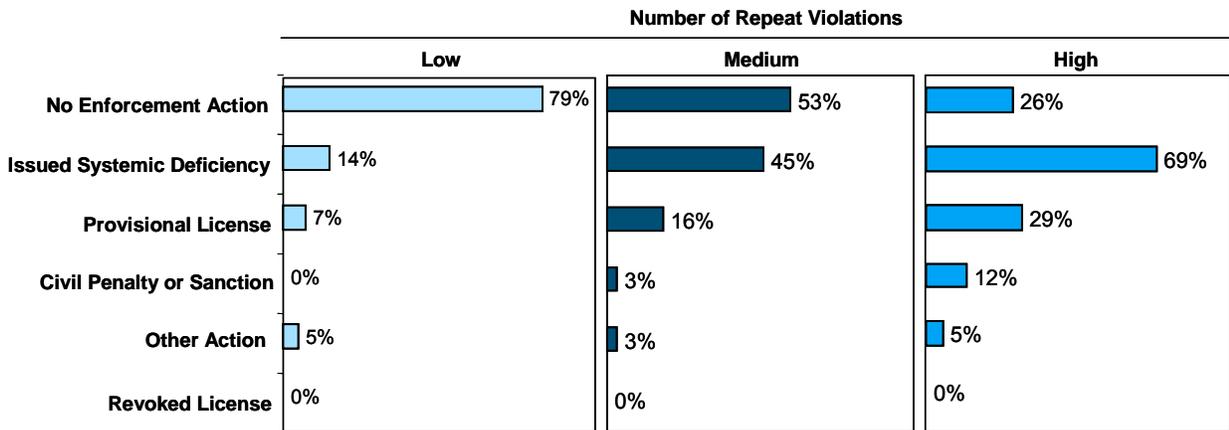
However, if facilities are cited for repeatedly violating the same standard, this suggests that corrective action plans may not always be an effective means of gaining compliance. Yet, among facilities with the most repeat violations (between 10 and 112 viola-

tions of critical standards), 26 percent received no formal enforcement action of any kind (Figure 14).

Agencies Issue Systemic Deficiencies and Provisional Licenses to Facilities with Uncorrected Violations or Broad Operational Problems. When cited violations suggest a facility is having problems with its overall operation, inspectors may issue a systemic deficiency. However, there does not appear to be much consistency in the use of this tool across agencies. For example, based on the number of systemic deficiencies issued and the total inspections conducted between 2003 and 2006, DMHMRSAS and DSS issued a systemic deficiency during every fifth or sixth inspection on average, but DOE only issued a systemic deficiency every 23 inspections, on average. DJJ reports that it does not issue systemic deficiencies at all.

The use of systemic deficiencies is highly consequential because facilities that fail to address systemic problems will have their license status reduced to provisional. Two or more systemic deficiencies issued during one inspection or the same systemic deficiency issued more than once during a licensure period leads to a provisional license. Once a facility has its licensure status lowered to provisional, it can no longer receive Title IV-E funding. If the status is lowered as the result of multiple health, safety, or human rights violations, additional placements are prohibited until full licensure status has been restored.

Figure 14: Twenty-Six Percent of Facilities With the Highest Numbers of Repeat Critical Violations Had No Enforcement Action



Note: "Other action" includes voluntary surrender of license, withdrawal of renewal application, or consent agreement.

Source: JLARC staff analysis of licensing data and enforcement action information from the Office of Interdepartmental Regulation, DSS, and DMHMRSAS for the period April 1, 2003, to March 31, 2006. Excludes DJJ data.

It is difficult to conclude whether agencies are effectively using provisional licenses as an enforcement tool. For example, as of March 31, 2006, less than one percent of open facilities had provisional licenses; however, based on data analyses, 29 percent of facilities with the highest numbers of repeat violations had a provisional license at some point during a three-year period (Figure 14). Licensing specialists report that they will be able to use this tool more effectively now that they are allowed to reduce a facility's license to provisional status prior to the expiration of its current license (a result of HB 577 enacted by the 2006 General Assembly). This suggests that the proportion of facilities with provisional licenses may increase in the future; however, staff at one agency admitted that they may be more reluctant to issue provisional licenses now that the penalties are significantly higher.

Agencies Rarely Revoke Licenses. Providers who continue to demonstrate noncompliance and fail to ensure the health and safety of residents may receive civil penalties or be forced to close; however, data from licensing agencies suggests that this rarely occurs. Between 2001 and 2006, ten facilities were issued civil penalties. Facilities regulated by DOE received no such actions because DOE does not have the authority to issue sanctions.

Facilities were even less likely to have their licenses revoked. Staff at one agency explained that "it would take an act of Congress to deny or revoke a license." Between 2001 and 2006, only two facilities had their licenses revoked.

Between 2001 and 2006, only two facilities had their licenses revoked.

Instead of taking formal enforcement actions, licensing staff explained that they are more likely to encourage new applicants to withdraw their applications and recommend that established facilities surrender their licenses or withdraw their renewal applications. Staff explained that negotiating a voluntary surrender of a facility's license "is less time consuming for everyone and has an immediate result." Between 2001 and 2006, agencies negotiated the voluntarily surrender of eight licenses as the result of multiple violations or serious incidents. During that time, agencies also entered into four consent agreements, which outline specific actions the provider will take to correct violations and come into compliance, rather than pursuing adverse action. At least seven facilities withdrew their initial or renewal applications after their licensing agency recommended denial.

Inadequate Enforcement Efforts May Jeopardize Children's Well-Being

High numbers of facilities with repeat violations suggest that licensing agencies are not always effectively compelling providers to comply with minimum standards. The following is a case example

of a facility that repeatedly violated a number of critical standards, without experiencing any consequences from their licensing agency:

Case Study

A residential treatment facility serving more than 80 children was cited for 25 violations of critical standards in three years. The licensing agency investigated at least eight founded complaints during that time, which included reports of medication errors, residents having sex with each other, and residents suffering injuries during restraints or seclusion. No enforcement action was taken, and the daily rate for this facility is approximately \$350.

It should be noted that enforcement efforts may be more effective now that agencies can reduce a license to provisional status at any time.

Less formal enforcement approaches are often appropriate when they achieve the intended result of either closing down a facility or bringing it into compliance; however, in cases when those actions are either inappropriate or unsuccessful, reluctance by agencies to take more formal enforcement could jeopardize the safety and well-being of children in facilities and place the State at risk of lawsuits. The following case study illustrates a facility that continues to serve vulnerable children despite severe and chronic compliance problems:

Case Study

The licensing division recommended revocation of a facility's license based on several serious incidents, including: allegations of staff sexual abuse of residents, serious assaults and suicide attempts which were not reported to the State, residents not being properly treated for injuries, and medication errors and cover-up of those errors. In one case, a resident suffered a concussion as the result of an assault by other residents before staff intervention. During that incident, staff were instructed not to call for emergency medical services. During the process of revocation, the State entered into a consent agreement with the facility, which included \$30,000 in fines. Since the agreement was reached, five former employees have been charged by police for abuses that occurred prior to the consent agreement, including having sex with a minor while in a custodial role, to contributing to delinquency, and failing to report abuse.

GREATER RESOURCES, CLARITY, AND AUTHORITY MAY IMPROVE OVERSIGHT

Although agencies are taking a variety of approaches to improve provider compliance, these actions may not be sufficient to ensure that children receive high quality services in safe environments. In order to improve State oversight of children's residential facilities, licensing agencies may need additional resources, clearer policies, and more formal training for licensing specialists. In addition, the interdepartmental program needs to ensure that facilities are regulated by agencies with necessary expertise. In light of agency reluctance to use revocation to close down facilities where children are being mistreated, greater accountability and transparency of agency decisions may be needed.

Agencies Report Having Inadequate Resources

A lack of resources reportedly affects the ability of agencies to conduct required inspections, complete thorough inspections, and take formal enforcement actions. In addition, agencies report that children's needs have become more complex, and as a result they are responding to more problems and complaints in their facilities than in the past. In order to maximize licensing resources, agencies prioritize which facilities they inspect and which standards they review for compliance. Although there is some evidence that agencies are understaffed, the extent of need is unclear.

Agencies Must Respond to More Severe Problems and Complex Programs. Enforcement resources may not have kept pace with the increasing number of children's residential facilities and the complexity of the problems exhibited by residents. For example, at DMHMRSAS, the ratio of licensing specialists to open facilities was about one to 16 in 1996, but is now roughly one to 36. Although increasing caseloads are less dramatic at the other agencies, the complexity of programs being licensed has increased for all agencies.

Stakeholders indicate that children's needs have escalated and, consequently, agency staff may have to spend more time responding to complaints and conducting immediate investigations into the reported concerns. Licensing specialists report that complaint investigations affect their ability to conduct unannounced inspections because they often demand high levels of agency resources, especially when complaints are severe. In addition, staff at DMHMRSAS and DOE report that complaints are often more serious or complex than in the past. For example, DMHRMSAS reports high levels of violence and mistreatment in their residential treatment facilities, including complaints of sexual abuse, neglect, violence, gang-like activity, and children running away. Data from

DMHMRSAS suggest that as of March 31, 2006, each licensing inspector was responsible for 19 open complaint investigations, lasting an average of 63 days.

Agencies Prioritize Which Facilities They Inspect to Optimize Use of Resources. Because of the limited number of staff available to conduct inspections and investigations, licensing agencies appear to be prioritizing inspections to problematic facilities. For example, DMHMRSAS staff report confronting the most serious problems in their residential treatment facilities, and analyses of licensing data suggest that they are inspecting those facilities more frequently than group homes. However, this approach places licensing specialists in a reactive role in which they are responding to compliance issues that have already become major problems, instead of a proactive role in which they can detect compliance issues before they escalate.

Limited Resources Appear to Reduce the Scope of Inspections. Licensing specialists report focusing on some standards more than others during licensing inspections, primarily due to resource constraints. Staff at each agency explained that they focus primarily on "health and safety" standards during unannounced inspections, although the specific set of health and safety standards reviewed may vary across agencies. In fact, one licensing specialist acknowledged that there may be some standards that are never reviewed for compliance. In light of resource constraints, agencies must prioritize standards, but this effort could contribute to inconsistencies in enforcement and impact agencies' abilities to monitor facilities' compliance with minimum standards.

Limited Resources May Prevent Agencies from Taking Formal Enforcement Action. A major obstacle that staff in Virginia identified as preventing them from revoking licenses is having sufficient resources to proceed through the formal appeals process that would follow a recommendation for revocation. Licensing staff expressed frustration about the amount of agency resources that must be devoted to the Administrative Process Act (APA), which affords providers the right to appeal an agency's revocation decision. For example, staff at DMHMRSAS explained that during their last attempt to revoke a facility's license, one staff person was assigned to that case full time for four months. When that person represents over a quarter of the agency's resources to oversee children's residential facilities, the process can severely impede the ability of the agency to conduct required inspections. To the extent that a lack of resources prevents agencies from taking formal enforcement actions that would otherwise be deemed necessary, this could have serious implications for the well-being of children in residential facilities.

Licensing Agencies Should Document Need for Resources and Seek Opportunities to Maximize Efficiency. Because agencies repeatedly and uniformly identified a need for additional resources, licensing divisions should take steps to quantify and demonstrate the additional resources they need. The National Association for Regulatory Administration (NARA) has developed guidelines that licensing agencies could use to assess their workloads and resource needs. According to those guidelines, agencies would have to assess a number of factors, including statutory requirements, scope of regulations to be enforced, number of licensed facilities and complexity of programs, number of new applicants, frequency of required inspections, number of complaint investigations, time spent on formal appeals processes, and other administrative activities such as maintaining records, staff training, and travel.

Recommendation (1). The Secretaries of Health and Human Resources, Education, and Public Safety should request that the licensing divisions conduct workload assessments for the purpose of specifically determining what additional resources are needed to address the findings presented in this report.

Another means of maximizing the efficiency of existing resources may be to ensure that individuals are serious about their decision to apply for a license. Licensing specialists spend a lot of time processing new applications and providing technical assistance to applicants who ultimately withdraw. DSS, for example, requires new applicants to attend two training sessions during the application process. To address this issue, the State could consider imposing application and licensing fees which are commensurate with the cost of processing applications. Unlike many other businesses regulated by the State, children's residential facilities currently do not have to pay a fee when applying for a license. These funds could be designated to provide additional training for providers who are interested in improving their programs.

In addition, licensing staff indicated that requiring new applicants to conduct a needs assessment prior to applying could help save agency resources. Licensing staff must approve the facilities' policies and procedures and conduct an on-site inspection before issuing a license. New applicants could be required to identify the number and specialties of facilities near the proposed site, contact local referring agencies to confirm that a need for the proposed program exists in the area, and provide a list of agencies that plan to use the new facility. While a needs assessment requirement may not be used to deny applications, it may be a useful exercise for prospective providers to consider whether their business plan is valid and whether it could be improved to better meet the needs of children.

**North Carolina
Requires Needs
Assessment**

North Carolina requires applicants to submit a needs assessment as part of the initial licensure process, including a list of agencies that will refer clients to them.

More than half of facilities that opened since 2000 closed within two years of applying, and nearly three-quarters closed within three years.

In addition to saving licensing resources, a needs assessment could help to limit the number of facilities that go out of business and address concerns about the clustering of facilities in certain areas of the State. For instance, more than half of facilities that opened since 2000 closed within two years of applying, and nearly three-quarters closed within three years. Furthermore, not conducting a needs assessment could also exacerbate the clustering of residential facilities in certain parts of the State (see Chapter 5, Figure 35). This clustering can create substantial costs for localities that host a high number of facilities. Moreover, there appears to be a mismatch between the location of residential facilities and the communities that need those services. As a result, many children are being served outside their communities and may not realize as much progress as they could if they remained closer to their families.

Recommendation (2). The General Assembly may wish to consider directing the interdepartmental program to collect application or licensing fees commensurate with the cost of processing those applications and earmark those fees for a training fund for residential providers. In addition, the interdepartmental program should require new applicants to submit a business needs assessment along with an application for licensure demonstrating a need for the services in the intended location.

Another means of improving efficiency and better utilizing licensing resources might be to consolidate regulatory functions into one agency. This step would afford greater flexibility to the single agency to direct resources where they are most needed. In addition, centralizing regulatory functions could also improve consistency in interpreting standards and taking enforcement actions, which could also help providers to better understand what is expected of them and the consequences of noncompliance. This step may also facilitate the process of sharing information with referral sources that currently have to contact four separate agencies to obtain compliance records for the residential facilities that serve children in their local programs.

Despite these potential benefits, licensing staff expressed concern about the loss of expertise that could result from separating licensing resources from the agencies that focus on particular populations. For example, staff from DMHMRSAS explained that being part of that agency enables them to build expertise in regulating facilities that serve residents who suffer from mental health problems. Further study of the benefits and drawbacks of consolidating regulatory resources should be conducted to determine the validity of this option.

Recommendation (3). The joint subcommittee studying the Comprehensive Services Act should evaluate the benefits and drawbacks of consolidating under one agency the licensing and regulatory functions currently carried out by the Departments of Social Services; Mental Health, Mental Retardation, and Substance Abuse Services; Education; and Juvenile Justice, and coordinated by the Office of Interdepartmental Regulation.

Agencies May Lack Clear Guidelines and Authority for Taking Enforcement Action

Licensing staff may not take formal enforcement actions consistently and uniformly because they lack proper guidance, receive insufficient training, and are subject to strong public pressure. Specific policies should be formulated to outline when agencies should take various enforcement actions based on the relative importance of standards and severity of violations. Additional training and increased transparency of compliance problems may address these issues.

Greater Clarity Could Facilitate More Consistent Enforcement.

There currently appears to be a lack of direction to guide licensing staff's decisions to pursue formal enforcement actions. With the exception of the Department of Juvenile Justice, licensing agencies have no formal system for differentiating the relative importance of standards, even though licensing staff report making these distinctions individually when determining appropriate actions to bring providers into compliance. For example, although the provider community expressed frustration about being cited for documentation violations they feel do not reflect their overall operation, licensing staff explained that documentation problems typically do not rise to the same level as problems with other standards that have a more direct impact on the health and safety of residents. Because licensing agencies appear to be prioritizing standards, the interdepartmental program should consider formalizing policies that address which standards should be weighed most heavily when taking enforcement action.

In addition, agencies may interpret and utilize systemic deficiencies differently because it appears that the parameters for issuing them are very broad. OIR's procedure manual for interdepartmental regulation states that "the regulator, exercising judgment and discretion, determines if the circumstances constitute a systemic deficiency." It describes circumstances that could lead to systemic deficiencies, such as numerous violations in one or more program components, one or more serious violations, or a recurring problem, without specifying what constitutes "numerous" or "serious." Without more specific criteria, licensing specialists may utilize this tool inconsistently or less effectively. Since multiple or repeated

systemic deficiencies lead to provisional license status, which could affect a facility's admissions and funding, it is especially important that agencies have clear guidelines for taking this action. In the absence of specific parameters, licensing specialists must decide for themselves what constitutes a systemic deficiency, often with very little formal training.

In addition to a lack of clear guidelines for issuing systemic deficiencies, agencies also do not appear to have clear guidelines for taking other enforcement actions. For example, agencies can recommend reducing licensed capacity of a facility, prohibiting new admissions, assessing civil penalties, or ultimately revoking or refusing to renew a license. However, agencies rarely take these actions. The *Code of Virginia* affords agencies much latitude by allowing them to take enforcement action when facilities violate laws or regulations which affect the human rights of consumers or result in a substantial threat to resident safety, health, or well-being. However, without more specific criteria, agencies may not feel empowered to take these actions, especially given the potential time and resource commitment that may be required. Furthermore, DOE does not have the statutory authority to take most of these enforcement actions. In the absence of clear guidance about when these actions are reasonable and necessary, facilities may continue to operate despite repeated or serious violations.

Recommendation (4). Clear guidelines for issuing systemic deficiencies and taking enforcement actions based on the scope and severity of violations should be developed by June 30, 2007.

Licensing Staff Receive Little Formal Training. Licensing specialists report that they receive little training in several areas that could affect their ability to monitor compliance with standards related to medication management, psychological diagnoses, and behavior management. A lack of training in these areas may preclude licensing specialists from identifying problems and helping providers to fully comply with standards and improve the quality of their programs. According to the National Association for Regulatory Administration (NARA),

. . . ample time should be allowed for ongoing staff training and development. Licensing staff must be experts in the area(s) in which they work. They need to be kept informed of major developments in research and of innovations in program design and implementation.

Staff from one agency indicated that in the past they reviewed standards during staff meetings, but they discontinued that practice when they became too busy. A supervisor of another licensing

division explained that "right now, we squeeze training into staff meetings. We really don't have the luxury of time to send people to training on any sort of comprehensive basis." Although OIR provides training, licensing specialists report that they receive little beyond initial training. To the extent that standards are vague or subjective, training may be especially important to ensure consistency in interpretation.

Recommendation (5). The Office of Interdepartmental Regulation should ensure that training of licensing staff is conducted and addresses interpretation of key standards, policies for issuing systemic deficiencies, procedures for taking formal enforcement actions, and other needs identified by licensing staff.

Department of Education May Not Be an Appropriate Lead Agency. Although education may be the primary purpose of some facilities, all residential programs also provide for the supervision, protection, and care of children, which may suggest that DOE is not the most appropriate agency to act as primary regulator for children's residential facilities. Staff at DOE explained that all children who receive residential services have needs beyond those addressed in a classroom; otherwise, a private day school would be an appropriate setting to meet their needs. In fact, according to responses to the JLARC staff survey of residential providers, over one-third of children in facilities licensed by DOE exhibit behavioral disorders, multiple mental health diagnoses, and emotional disturbances (Table 14). In addition, over a quarter of the residents are mentally retarded.

Table 14: Children in DOE Facilities Exhibit Variety of Problems

Behavior	Percent of Children Who Exhibit the Behavior
Behavioral disorders	39%
Multiple mental health diagnoses	36
Emotional disturbances	34
Mental retardation	26
Substance abuse	16
Psychotic disorders	14
Autism	11

Note: Analysis based on seven survey responses from DOE licensed facilities.

Source: JLARC staff analysis of results of residential facility survey.

DOE staff explained that, with the exception of a few facilities, most children who are referred to their programs are not referred for educational reasons. Furthermore, many of their facilities also have a treatment component. For example, DOE staff explained that several facilities they license provide mental health services, which could make DMHMRSAS a more appropriate lead agency.

To the extent that those facilities are providing mental health rather than education services, the result could be that DOE staff lack appropriate backgrounds to identify and address the needs of this population. Further, it could increase the liability of that agency. For example, one of the children who died in a group home licensed by DOE had both autism and mental retardation.

Case Study

A 13-year-old boy asphyxiated on his vomit during a restraint at a group home a day after being admitted. Prior to being admitted, the child received services in a training center and a mental health institute to manage his aggressive behaviors. While in the institute, he was determined to need residential care and was referred by a parent and CSB case manager to the group home. The incident was investigated by DOE, DMHMRSAS, and the Office of Human Rights; however, neither the incident nor violations that contributed to it were related to the resident's educational needs or services.

Not all DOE facilities serve children with mental health needs, but the custodial care provided by those facilities could be overseen by DSS. Further, if DOE served only as a secondary regulator, this might allow them to better focus their efforts on the educational components of each facility. If it is determined that DOE is not an appropriate lead agency, however, agencies that must absorb the additional workload would need more resources, especially given that licensing agencies already cannot meet their statutory requirements.

Recommendation (6). The General Assembly may wish to consider amending the *Code of Virginia* to direct the Department of Education to license and regulate only the educational component of residential schools rather than serve as the primary regulatory agency in these facilities. The Department of Education's budget and staffing allowance associated with regulating the non-educational components of residential schools should be transferred to the regulatory agencies that are assigned primary responsibility for licensing and regulating the non-educational components of residential schools.

Increased Transparency May Facilitate Formal Enforcement Actions. Licensing staff frequently indicated having to balance multiple interests when deciding whether to take formal action against non-compliant facilities. While safeguarding the health and safety of children is of primary concern, licensing agencies must also answer to providers whose livelihood can be threatened by regulatory action, and to case workers who may have difficulties securing alternative placements when a facility's license is suspended or revoked.

Increasing the transparency of the enforcement process could help to hold licensing agencies more accountable while providing them with the support they need to respond to conflicting public pressures. In particular, periodic reports could be made to the CSA program's State Executive Council (SEC), which includes all major stakeholders of children in residential programs. These reports could identify significant problems occurring in children's residential facilities, as well as actions taken by licensing agencies to address those issues. Members of the SEC, which include commissioners or directors of each licensing agency, could provide pressure and support to the licensing divisions to ensure that necessary enforcement actions are taken.

Recommendation (7). The State Executive Council should require licensing divisions to present during their quarterly meetings a summary of significant compliance problems identified and the enforcement actions taken or proposed to address each problem.

LICENSING STANDARDS COULD BE STRENGTHENED

Current regulations, even if properly enforced, do not appear to be sufficient to consistently preserve the health and safety of children in residential facilities. In fact, a convergence of evidence suggests that simply meeting the minimum requirements set forth in current standards may not be sufficient to minimize serious incidents. There is strong consensus among staff from the four licensing agencies that current standards should be strengthened in several key areas, based on their experience inspecting facilities and investigating serious complaints. Furthermore, most providers who responded to a JLARC staff survey acknowledged that stricter licensing standards would be at least somewhat effective in improving the quality of residential services, and many of them already exceed minimum requirements of their own accord. In addition, standards that are more stringent than Virginia's have been adopted by several states and recommended by national experts. Having clearer and stronger standards would not only raise the overall quality of services in the State, but would also enable agencies to prevent minimally qualified providers under current standards from entering the market. The Office of Interdepartmental Regulation (OIR), with assistance from the four licensing agencies, proposed revisions to some of the interdepartmental standards in 2004. However, those revisions have not been released for public comment.

Vague Standards Preclude Enforcement Action and May Not Achieve Intended Purpose

Several Virginia standards may be too vague to be actionable and to guarantee the safety of residents, according to licensing staff. For example, standards require facilities to develop policies that address staff supervision of children without specifying what those policies should include, yet licensing specialists must review and approve them. Supervision policies that do not adequately meet the needs of the population served could result in insufficient oversight, which could lead to the development or escalation of incidents among residents. Similarly, standards require facilities to develop staff training plans without indicating what those plans should contain. If the standards intend to require that facilities not only have supervision policies and training plans, but also have adequate policies and plans that specifically address how the facilities will supervise children and train staff, those requirements should be outlined in regulations and reinforced through interdepartmental training.

Vague standards may not achieve their intended purposes for two primary reasons: (1) licensing specialists may not be able to interpret them or understand their intent, and (2) agencies may not be able to hold providers accountable if specific requirements or prohibitions are not included in the regulations. Although licensing staff caution that flexibility allows the regulations to be applied across many types of residential programs, some standards may need to be clarified to achieve consistency in interpretation and enforcement.

Virginia Standards May Not Ensure Safe Environment

Interdepartmental standards must set forth *minimum* levels of required performance in children's residential facilities, according to the *Code of Virginia*. Consistent input from licensing staff, other states' standards, national experts' recommendations, and the practices of many Virginia providers suggest that these minimum requirements may be too low in several areas that are key to residents' health and safety. Although revisions to interdepartmental standards were proposed more than two years ago to address many of these shortcomings, these revisions have not been released for public comment by the Governor's office.

Minimal Staffing Ratios May Not Ensure Adequate Supervision. Children who receive residential services tend to suffer from serious behavioral and emotional problems that must be monitored to prevent incidents, but licensing specialists report that meeting Virginia's required staffing ratios does not always ensure that facilities will be able to provide adequate protection, guidance, and

supervision to residents. Currently, one direct care staff is allowed to supervise and address the needs of up to ten children with complex needs (Table 15). Further, standards do not require personnel other than direct care staff to be present at the facility. As a result, under current standards it is permissible for direct care staff with little or no experience to provide the supervision and care of children with serious emotional and behavioral problems.

Table 15: Virginia Standards for Staff-to-Resident Ratios

Shift	Program Type	Ratio
Daytime	Medicaid-certified facilities (Levels B and C)	1:4
	Mother-baby, Medicaid-certified facilities (Level A)	1:6
	Licensed by DMHMRSAS	1:8
	All others	1:10
Nighttime	Medicaid-certified facilities (Levels B and C)	1:8
	Mother-baby, Medicaid-certified facilities (Level A)	1:10
	All others	1:16

Source: 22 VAC 42-740 and Department of Medical Assistance Services provider manual.

Inadequate staffing ratios that result in a lack of supervision can directly impact the health and safety of residents. For example, DMHMRSAS staff report that inadequate staffing levels may contribute to high levels of violence in residential treatment facilities, as illustrated by the following case study:

Case Study

Over a three-month period, a residential treatment facility reported more than 100 incidents of fights and assaults, group fights, and alleged abuse by staff. These incidents resulted in more than 60 injuries, including lacerations, strains, and fractures. Licensing specialists determined that facility staff were afraid for their safety and failed to intervene when they felt they had inadequate staff reinforcement. The daily rate for that facility is more than \$400 per child.

In addition to being of concern to most licensing specialists, the provider community appears to have recognized that minimum ratios are inadequate, and many facilities are staffing at a ratio that is more stringent than what is required of their own accord. In fact, approximately 80 percent of facilities report meeting direct care staffing ratios recommended by national model standards developed by the Child Welfare League of America (CWLA). CWLA recommends a minimum of one direct care staff for every six residents in group homes, with more stringent ratios applicable to more intensive facilities.

A review of the licensing standards in eight nearby states also revealed that six of those states have more stringent staffing ratio

Child Welfare League of America Developed Model Standards

The Child Welfare League of America (CWLA) developed the Standards of Excellence for Residential Facilities, which represent practices that are considered most desirable for serving children and families. CWLA standards were developed with contributions by national organizations, government agencies, human service departments, private agencies, universities, and professional associations in related fields.

Several States Have More Stringent Daytime Ratios

North Carolina requires staffing ratios of at least one to four in treatment facilities. Pennsylvania requires staffing ratios of one to four or one to eight, depending on children's ages. Kentucky requires a ratio of one to four in group homes and crisis intervention units. New Jersey requires a ratio of one to six and West Virginia and Tennessee both require ratios of one to eight.

29 percent of facilities surveyed by JLARC staff have no direct care supervisors on staff during weekend afternoons.

requirements than Virginia for at least some of their facilities. Furthermore, a survey conducted by the U.S. Department of Health and Human Services in 2003 and 2004 found that 46 percent of facilities that serve children with behavioral and emotional disturbances were required to have one staff person for every two to four residents (Table 16). By contrast, only 17 percent of facilities in Virginia (certain Medicaid-certified facilities) are required to staff at a ratio of one staff person to four residents. In fact, 41 percent of facilities are required to have only one staff person for every ten children.

Table 16: Facilities in Virginia Have Lower Required Staffing Ratios than Other States

Staff-to-Resident Ratio	Percent of Facilities	
	Virginia	Nationwide
2-4 residents per staff	17%	46%
5-8 residents per staff	41	34
9-20 residents per staff	41	13

Note: Analysis includes DOE-, DMHMRSAS-, and DOE-licensed facilities on March 31, 2006.

Source: JLARC staff analysis of licensed facilities on March 31, 2006, and U.S. DHHS Report on State Regulation of Residential Facilities for Children with Mental Illness.

Standards Do Not Adequately Address Supervision of Direct Care Staff. In addition to having enough staff to adequately supervise residents, it is also critical that staff receive oversight and guidance from more qualified individuals. Currently, standards specify that individuals supervising direct care staff must have either a bachelor's degree or a high school degree with five years of experience, two of which must be in a residential facility. However, standards do not indicate when supervisors of direct care staff must be present at the facility. As a result, in some cases, a single direct care staff may be on duty without any reinforcement or supervision. Twenty-nine percent of the facilities surveyed by JLARC staff report having no direct care supervisors on duty during weekend afternoons, which is the time when facilities tend to have the least amount of staffing on-site. The following case study illustrates an instance in which additional staffing or staff supervision could have helped to prevent a child's death:

Case Study

A child died after being placed in a chokehold by another resident. At the time of the incident, only one direct care staff was on duty and that person allowed the two residents to engage in "horseplay," even though this was against house rules and the residents' service plans. Further, the staff person failed to promptly seek medical attention when the resident had difficulty breathing. Had there been a supervisor on duty, licensing specialists indicated that the incident may

have been prevented, and an appropriate decision to contact medical professionals or EMS may have been made.

Some States Require Greater Oversight of Staff and Case Management

In addition to direct care staff-to-child ratios, New Jersey stipulates that there must be one social service worker for 20 children. Delaware requires facilities to have a direct care supervisor for every ten direct care staff.

Although not addressed in Virginia standards, nearly two-thirds of providers feel that supervision of direct care staff is critical to ensuring high quality residential programs. Also, CWLA states that "supervision [of staff] is key to providing competent, goal-directed services." As a result, CWLA recommends a ratio of one supervisor to every four direct care staff in residential treatment facilities during all shifts. Approximately 40 percent of surveyed residential treatment facilities already meet CWLA's recommended ratio for direct care supervisors during the daytime, but only 14 percent meet the ratio for nighttime.

In order to improve program oversight and supervision of staff, licensing specialists and some residential providers indicated that certain key positions should be full-time and on-site, such as chief administrative officers (CAOs), program directors, and case managers. Currently, only facilities licensed to serve 13 or more children are required to have a full-time program director, while requirements for the other positions are not addressed by standards at all. A lack of full-time program directors and administrators affects the amount of guidance available to staff and supervision over children. Staff at one agency gave an example of a situation in which one person is serving as program director of multiple facilities, which has led to severe supervision issues that could ultimately result in sanctions. According to survey results, 83 percent of facilities report having both a full-time CAO and program director. Five percent, however, have neither.

Staff Training Is Not Adequately Addressed by Standards. Providers rank staff training as a critical factor in ensuring quality services, and most nearby states require a minimum amount of annual training, but licensing staff report that training is not adequately addressed by Virginia standards. Standards require at least one person on site to be trained in first aid and CPR and also require training for staff who administer medications, but they are less specific about the amount or frequency of training that is necessary for staff to perform their other job responsibilities. Licensing specialists expressed particular concern about the need for facility staff to receive training that is specific to the population they serve and also addresses child development, use of restraints, and crisis management.

The following case study illustrates how a lack of training may contribute to serious incidents:

Case Study

A residential treatment facility experienced chronic violence between residents in 2005. Facility staff reportedly could not carry out appropriate behavior interventions to prevent the assaults. Incident reports noted resident-to-resident violence and intimidation including children being punched, slapped, kicked, and jumped by other children. One child reported that he did not feel safe because staff "don't know what they are doing."

Although interdepartmental standards do not specify minimum requirements for initial or annual hours of training for direct care staff at children's residential facilities, the State does outline those requirements for other types of facilities it regulates. For example, according to emergency regulations for assisted living facilities (ALFs), direct care staff in ALFs must complete 40 hours of department-approved training within the first two months of employment, an additional 12 hours within the first year, and 16 hours annually thereafter. ALF standards also prescribe additional training requirements for staff serving special populations. For example, staff serving residents in special care units must complete an additional 40 hours of department-approved training.

Most nearby states outline minimum annual hours of training for direct care staff (Table 17). Seven out of eight nearby states require between six and 40 hours of annual training for staff who work directly with children. Several states also outline specific topics that must be addressed through training, such as emergency and first aid procedures, behavior management, service delivery, abuse and neglect laws, suicide prevention, and physical restraint and de-escalation techniques, among others.

Table 17: Other States Have Minimum Training Hours for Staff Working Directly With Children

State	Annual Training Hours Required
Virginia	0
North Carolina	0
Tennessee	6-12
New Jersey	12
West Virginia	15
Pennsylvania	40
Maryland	40
Kentucky	40
Delaware	40

Source: JLARC staff analysis of other states' statutes and regulations.

Qualification Standards for Direct Care Staff May Not Be Sufficient to Promote Well-Being of Residents. Licensing specialists consistently expressed concern that direct care staff who possess only the minimum qualifications required by Virginia standards may not be able to respond to issues that compromise child safety. Although direct care staff are responsible for much of the day-to-day care of residents, Virginia standards only require them to have a high school degree or G.E.D. and do not require them to have previous experience in a residential setting or with children with similar behavioral or emotional problems. In contrast, CWLA also recommends that direct care staff have a minimum of two years' post-high school education, and three out of eight neighboring states require direct care staff to be over the age of 21. When coupled with a lack of training requirements, these minimal qualifications may be of particular concern.

Licensing staff explained that a lack of adequate and qualified staff contributes to incidents such as staff members having sexual relationships with residents, inappropriate or excessive restraints, resident-to-resident assaults, staff locking children out of facilities, and inappropriate activities by residents left unsupervised, among others. In addition, a lack of professional training can result in inappropriate conduct by staff, and also deprives residents of strong role models for responsible adult behavior, as illustrated by the following case study:

Case Study

In 2006, a resident was assaulted and seriously injured by four other residents. Facility staff reportedly violated numerous policies and procedures, and their negligent behavior directly contributed to the assault. In fact, staff allowed residents to enter residential units that were off limits to them based on aggressive and predatory behavior. Residents then attacked the victim, causing a broken nose and black eye. Staff in the facility met the State's minimum qualification requirements.

Additional Standards May Be Needed to Ensure Child Safety. Licensing specialists also report that certain gaps in standards could affect the safety of children in residential facilities. For example, they noted that off-premise staff should be required to be trained in first aid and CPR, first aid kits should be required in all vehicles, staff overseeing water sports should be trained in water safety, and staff should have to document medication refusals. These shortcomings in Virginia standards increase the possibility of serious injuries if facilities' staff are unable to respond to incidents. For example, three residents have drowned since 2001 while in the custody of residential facilities. Some of these issues have

been addressed in emergency regulations to meet requirements of House Bill 577 (2006).

Virginia standards allow facilities to provide a minimum level of care that does not appear adequate to ensure basic protection and supervision of residents.

Level of Care Permitted by Virginia Standards May Be Inadequate.

Virginia standards allow facilities to provide a minimum level of care that does not appear adequate to ensure basic protection and supervision of residents. Of particular concern is the amount and scope of responsibilities of direct care staff who may have little training and experience and may also receive little guidance, supervision, and reinforcement from more experienced individuals. Providers in the Commonwealth have reported that in many cases they exceed minimum requirements in an effort to provide high quality residential services. However, providers who do not exceed standards could jeopardize the well-being of children they serve.

For example, current standards would allow a single direct care staff person who is 18 years old to oversee the supervision and care of ten residents who are also 18 years old and have behavioral disorders or emotional disturbances. The staff person does not need to have experience working with this population and may have no substantial training beyond initial orientation to the facility's policies. This staff person could be permitted to not only supervise this group by her or himself, but also arrange and provide services to meet individual needs, monitor behaviors, ensure provision of education services, provide counseling, and transport residents to appointments and activities. In addition, that staff person could also be solely responsible for developing and implementing resident service plans and administering physical restraint to residents who may exhibit aggressive behaviors.

Facilities Held to Higher Standards Experience Fewer Compliance Problems, Despite Serving More Difficult Populations

Being subject to more stringent standards could help facilities to better comply with requirements and ensure the health and safety of their residents. Facilities that already meet higher requirements than those specified in the interdepartmental standards in order to be certified by Medicaid or accredited by national and State organizations (such as the Council on Accreditation, the Virginia Association of Independent Specialized Education Facilities, and the Joint Commission on Accreditation of Healthcare Organizations) tend to have a better compliance record than other facilities. In 2005, Medicaid-certified and accredited facilities were cited for approximately half as many violations as other facilities on average. Medicaid-certified facilities had six violations per inspection, accredited facilities had 5 violations, and other facilities had ten violations, on average. However, it is important to note Medicaid certification or national accreditations do not guarantee better per-

formance. While providers who met these additional requirements were generally performing at a higher level of compliance, licensing staff reported that some of the more severe violations and incidents they have investigated took place in facilities that were both Medicaid-certified and nationally accredited.

Interdepartmental Program Has Proposed Revisions to Several Key Standards, but No Action Has Resulted

The shortcomings inherent in Virginia standards have been widely recognized within the licensing community and have prompted licensing stakeholders to examine potential areas for change. A revision committee composed of the key licensing staff, OIR staff, CSA representatives, and representatives from the provider community proposed revisions to interdepartmental standards in 2004. The revisions proposed by the committee include

- increasing the staffing ratio from one staff to ten children to one staff to six children,
- requiring all direct care staff to receive first aid and CPR training,
- increasing qualifications of chief administrator officers, program directors, and direct care staff supervisors,
- outlining responsibilities and qualifications of case managers and requiring them to work full-time at group homes, and
- requiring facility staff to document medication refusals and actions taken.

Proposed regulations have not been released for public comment by the Governor's Office since 2004.

Though a draft of the proposed regulations was completed by the revision committee and submitted to the Secretary of Health and Human Resources and the Governor in 2004, the proposed regulations have not been released for public comment.

Furthermore, although proposed regulatory revisions address many of the issues described in this report, they do not address

- the vagueness of standards,
- the need for better supervision of direct care staff,
- which facility staff should participate in developing service plans,
- qualifications and training for direct care staff, and
- the need for certified lifeguards to supervise residents' aquatic activities.

In response to 2006 legislation calling for emergency regulations to address services deemed appropriate "to ensure the health and safety of the children" in residential facilities, emergency regulations have been proposed. However, the emergency regulations are much less comprehensive than earlier proposals and only mirror revisions to some of the staff qualifications discussed above. The emergency regulations have not been released from the Office of the Secretary of Health and Human Resources. (The emergency regulations were approved by the Governor on December 28, 2006.)

Recommendation (8). The Governor may wish to release for public comment the proposed regulations relating to standards in residential facilities that were submitted to the Governor and Secretary of Health and Human Resources in 2004, and approve the emergency regulations required pursuant to Chapter 781 of the 2006 Acts of Assembly.

Recommendation (9). The boards of the four agencies regulating children's residential facilities should direct agency staff to develop additional proposed regulations that address the findings of this report regarding the need for stronger standards governing the operation of residential facilities which are not currently addressed by the drafted proposed regulations. These additional proposed regulations should address vague standards, supervision of residents and staff, and training and qualifications of staff.

As previously indicated, many providers appear to already exceed required standards of their own accord (Table 18). This finding suggests that the additional cost of implementing more stringent standards is already partially reflected in current rates. Furthermore, implementing more stringent standards will only affect a subset of providers.

It is important to note that securing additional and/or better qualified staff may be difficult for some providers, particularly those in less populous areas. Providers reported experiencing high rates of turnover among direct care staff (28 percent during the past year), which suggests that attracting and retaining staff is already a challenge. Additional training could, however, help recruitment and retention efforts. For example, the Human Services Research Institute (HSRI), which developed a set of skill standards for direct care workers, reported:

There is a consensus in the field that current preparation of many human services workers is grossly inadequate. The poor preparation, and the resulting lack of fit between attitudes and competencies of these workers and the demands of their jobs, is one major cause of extremely high turnover rates of direct service workers.

Table 18: Percent of Staff and Facilities That Meet Recommended Standards

CWLA Standard		Percent of Staff Who Meet Standard	
Staff Qualifications	Chief Administrative Officer	Education 61%	Experience 65%
	Program Director	54	79
	Direct Care Staff	48	92
	Direct Care Supervisors	21	na
	Case Manager	50	na
CWLA Standard		Percent of Facilities That Meet Standard	
Staffing Ratios		Day	Night
	Direct Care Staff	82%	80%
	Direct Care Supervisors	38	14
	Case Managers	34	na
Practice Recommended by Licensing Specialists			Percent of Facilities That Comply
Full-time Chief Administrative Officer			87%
Full-time Program Director			91
Staff participating in developing service plans have either Master's degree or clinical background			78

Source: JLARC staff analysis of CWLA Standards for Excellence for Residential Services, interviews with licensing specialists, and provider survey data.

HISTORY OF VIOLATIONS AND FATALITIES UNDERSCORES NEED FOR IMPROVING VIRGINIA'S REGULATORY PROCESS

Although interdepartmental standards are minimum requirements which may in some cases be inadequate, certain facilities are not in compliance with numerous standards. In particular, group homes, newer programs, and for-profit facilities tend to have more violations than other facilities. This finding supports the concerns expressed by licensing specialists and referral sources interviewed for this study about the quality of these types of facilities. Furthermore, 12 children have died by other than natural causes while in the care of facilities licensed and regulated by the State since 2001. Some of these fatalities might have been prevented through better enforcement of current standards and/or more stringent requirements. These findings underscore the importance of monitoring and enforcing compliance, as well as establishing minimum standards that better ensure the health and safety of children in residential facilities. The extent to which violations threaten children's safety may be partially mitigated by the fact that most children appear to be placed in facilities that have an above-average compliance record.

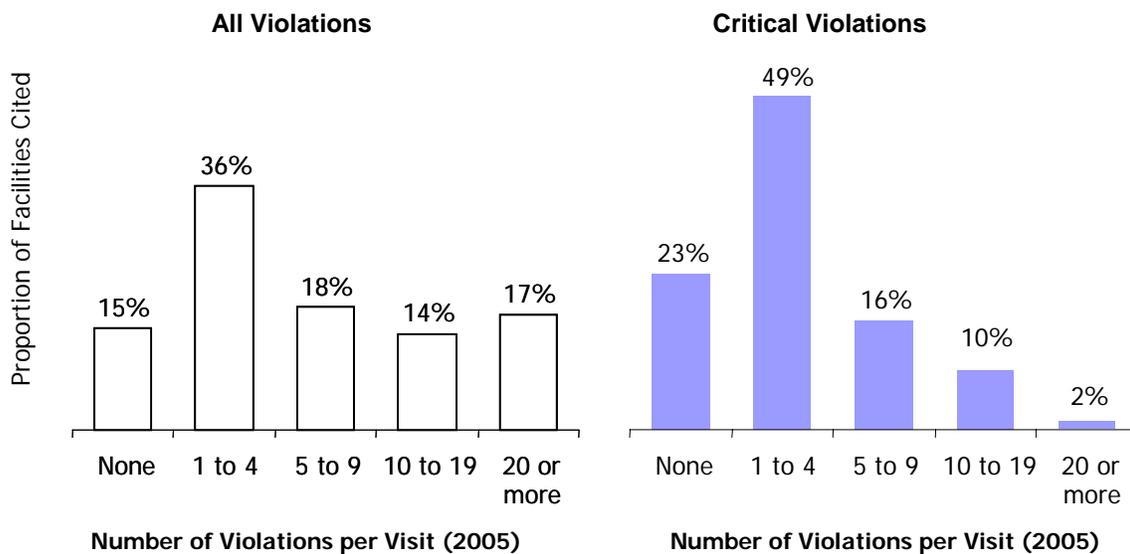
Some Facilities Are Cited for Numerous Violations, Despite Standards Being Minimal

On average, children's residential facilities were cited for nine violations during each inspection conducted between April 2005 and March 2006. Most facilities were either in full compliance with licensing standards (no violations) or were cited for a lower than average number of violations. However, 17 percent of licensed facilities were cited for 20 or more violations per inspection (Figure 15). One facility received an average of 53 violations per inspection during that year.

Licensing specialists indicated that while all standards are important, certain standards are especially critical to ensuring the health and safety of residents (Table 13). Between 2005 and 2006, facilities were cited for an average of four critical violations per inspection. During that time, a quarter of facilities received no critical violations (Figure 15). Twelve percent, however, were cited for ten critical violations or more.

Certain types of facilities tended to be cited for a larger number of violations. Group homes were cited for an average of ten violations per inspection compared to residential treatment facilities which were cited for an average of six violations per inspection between

Figure 15: Some Facilities Have High Number of Violations of Interdepartmental Standards



Source: JLARC staff analysis of licensing data between April 1, 2005 and March 31, 2006.

April 2005 and March 2006. Group homes also averaged six critical violations per inspection while treatment facilities averaged four. In addition, all types of residential facilities appear to have a higher number of violations per inspection in their first years of operation, but compliance improves over time. Facilities averaged 13 violations per inspection within their first two years of operation while facilities in operation ten or more years averaged seven violations per inspection. By the third year of operation, however, facilities averaged nine violations per inspection, and this further decreased to eight violations in the fourth year.

Finally, for-profit facilities were cited for ten violations and six critical violations on average while non-profit facilities were cited for eight violations and four critical violations on average between April 2005 and March 2006. This trend may be, in part, attributable to the fact that a disproportionate number of for-profit facilities are newer and, as a result, undergoing the same learning curve described above. However, licensing specialists expressed concerns that many new providers are entering this field because they have heard it is profitable. In fact, for-profit facilities represent over two-thirds of the new facilities operating during this period.

Improving Virginia's Regulatory Process Could Reduce Fatalities in Residential Facilities

In extreme cases, a lack of adequate enforcement and/or sufficiently high standards may contribute to serious harm or even death. These extreme cases serve as an indicator that there may be reason to be concerned about the regulatory process that oversees children's residential facilities. In the past five years, 12 children died by other than natural causes while in the custody of residential facilities licensed and regulated by the State (Table 19, page 56). By contrast, no death occurred in juvenile correctional facilities during the same timeframe. Some of the deaths described in Table 19 may have been prevented had providers been in compliance with current standards and/or met more stringent standards, such as providing greater supervision to their residents and staff.

Data on Residential Placements

JLARC staff obtained placement information from CSA coordinators on more than 2,000 children served in residential facilities between July 1 and December 31, 2005.

Most CSA Children Are Placed in Facilities with Better than Average Compliance Records

Most CSA participants are not placed in those facilities that fail to comply with a large number of interdepartmental standards. The majority who received residential services during the last six months of 2005 were placed in facilities with a smaller number of violations than the average. Eighty-two percent of these children

were placed in facilities cited for nine violations or fewer, and three-fourths were placed in facilities cited for four critical violations or fewer.

This trend may be partially due to the fact that most CSA children were placed in facilities that had operated for some time. As described previously, more established facilities tend to have fewer violations. While 20 percent of children were placed in "newer" facilities (operating two years or less), half were placed in facilities operating ten years or more. Furthermore, 26 percent were placed in facilities operating 20 years or more.

Table 19: Summary of Deaths by Other than Natural Causes in Children's Residential Facilities Since March 2001, by State Licensing Agency

Facility Type	Description of Cause of Death	Action Taken
Department of Mental Health, Mental Retardation and Substance Abuse Services		
GH*	15-yr-old male drowned while swimming at a lake on an outing.	License reduced to provisional status in preparation for revocation. Provider surrendered license.
GH	Resident drowned while swimming in the James River with three other residents.	License reduced due to multiple violations. Provider surrendered license.
GH*	15-yr-old female was electrocuted in a power substation after running away from nearby group home.	Investigation determined that provider did not neglect child.
GH*	Child died during "horseplay" with another resident.	Provider placed on provisional license which resulted in no new admissions. Census reduced to one resident.
RTF	Resident was noted to be unresponsive to morning wakeup. A nurse was notified and CPR was initiated.	Facility had multiple violations. License was reduced from triennial to annual during next licensing period.
RTF	Resident died of natural causes, but issues were found related to accessing emergency care.	License reduced. Informed placing agencies. Provider changed policies for accessing emergency medical care.
Department of Social Services		
GH	Resident was helping a neighbor push a vehicle out of the snow. Vehicle rolled back over the resident and killed him.	No enforcement action.
RTF**	Resident drowned in a jacuzzi while supervised by non-staff member who had not been briefed on the resident's medical condition.	\$1,500 civil penalty issued by Department.
Department of Education		
GH	Resident asphyxiated during restraint.	Numerous violations found. Provider placed on provisional license due to death and other serious incidents.
GH	Resident was kicked in the head by another resident. She received no immediate medical attention. She was taken to the hospital four days later and died there the following day.	Two violations found. No formal enforcement action.
RTF	Suicide by hanging.	No violations found.
RTF	Resident committed suicide by jumping from a bridge walkway.	No violations found.

Notes: Facility type is either group home (GH) or residential treatment facility (RTF). Facilities with (*) opened in the last five years. The facility with (**) is campus-style. Four additional deaths occurred during this time period in DMHMRSAS facilities due to natural causes. Another child with a hereditary disease ran away from a DJJ community youth home. He subsequently admitted himself into a hospital where he died. This was the only reported death in a DJJ community youth home. Deaths by other than natural causes occurred in 12 of approximately 364 residential treatment facilities that were in operation at some point during this five-year period.

Source: JLARC staff review of information provided by licensing divisions from the Departments of Mental Health, Mental Retardation and Substance Abuse Services; Social Services; Juvenile Justice; and Education.

State Lacks Mechanisms to Promote Effectiveness of Residential Services

In Summary

The principal measure of success for the CSA program is whether its participants improve after receiving services. Currently, no standard outcome measures exist, and available data that could be used to assess child outcomes are not always accurate or complete. Based on available information, it appears that many CSA participants experience improvements after receiving residential services. However, a substantial number of children do not appear to improve, and some even regress. Furthermore, local CSA coordinators and case managers report that residential services are not effective for a substantial number of children and that providers do not always deliver the quality of services expected by a locality. To enhance the effectiveness of residential services and maximize Virginia's investment, licensing standards could be revised to better ensure that programs are appropriately structured to deliver effective services and hold providers accountable by measuring the outcomes of former residents.

House Joint Resolution 60 places great emphasis on the importance of evaluating the quality of residential care. In addition to preserving the safety of children, the quality of residential services is characterized by the ability of residential providers to effectively help children overcome their problems. Given their sizeable investment in the CSA program, the State and localities should demand evidence that residential services are yielding positive results, yet such evidence is not readily available. Information analyzed for this study suggests mixed results about the effectiveness of residential services. The safety concerns raised in Chapter 2, coupled with a lack of mechanisms that hold providers accountable for the delivery of effective services, may partially explain why some children do not appear to improve.

ABSENCE OF OUTCOME MEASURES AND USABLE INFORMATION UNDERMINES UNDERSTANDING OF PROGRAM EFFECTIVENESS

Despite the importance of measuring program effectiveness, there is currently no system for measuring the outcomes of children who receive CSA services at the State level, and few local CSA programs formally track the outcomes of children they serve. Furthermore, information that could be used to measure child outcomes is not consistently accurate or complete. As a result, it is difficult to gauge the extent to which CSA services have addressed

children's individual needs or whether CSA funding has been well spent.

Measuring Effectiveness of Services Is Critical to Achieving Positive Child Outcomes and Returns on Investment

Outcome measures would provide policymakers with evidence that public funding is well spent.

Outcome measures are imperative to evaluating the efficiency and effectiveness of services and programs. In the context of CSA, developing outcome measures would benefit children and State and local governments in multiple ways. First, outcome measures would provide policymakers with evidence as to whether public funding is being well spent and guidance in allocating additional funding to the CSA program. Second, outcome measures would allow comparisons to be made among similar service providers to determine which provider characteristics appear to result in better outcomes and which services in the continuum of care appear to be most effective. This would ultimately assist local CSA program staff and case managers in determining the most appropriate services to meet children's needs. Finally, developing a better understanding of which services are most effective could also reduce spending in the long run if children are linked to better services earlier.

Outcome Measures Have Only Recently Been Discussed

Although CSA stakeholders and a review of the child welfare literature identified several indicators that could be used to determine whether children's emotional and behavioral problems improve, it appears that reaching consensus on which outcomes should be measured has been difficult. In particular, providers and local CSA program staff reported that children they serve have often very diverse and complex needs and that standardized measures may be overly simplistic. Given the importance of developing performance measures, the State Executive Council (SEC) and the State and Local Advisory Team (SLAT) have been working with staff of the Office of Comprehensive Services (OCS), local CSA programs, and service providers to reach consensus on universal outcome measures that transcend children's individual needs.

Though a final decision on which specific measures will be tracked is pending, these stakeholders have identified the proportion of children served in the community, changes in children's functioning, success in schools, and family satisfaction as key areas that should be captured. These measures are consistent with those identified by JLARC staff through discussions with providers and a review of the literature.

Since FY 2004, local CSA programs have provided information to OCS that would partly enable stakeholders to implement some of

these proposed outcome measures. However, concerns over the validity and scope of the data may undermine the State's ability to implement performance measures right away. Instead, changes to the current data collection process seem necessary in order to properly measure child outcomes and program performance.

Current Data Collected By Program Provides Limited Information on Child Outcomes

Although local CSA programs report child-level data to OCS that could be used to measure child outcomes, the quality and accuracy of this information is of concern. In particular, changes in children's scores on the Child and Adolescent Functional Assessment Scale (CAFAS) could be used to measure changes in child functioning. CAFAS is a standardized assessment instrument that measures the level of dysfunction exhibited by a child. However, staff in the majority of local programs visited by JLARC staff have expressed doubt over the validity of the CAFAS instrument, and scores are not consistently reported for all children.

During site visits conducted by JLARC staff, local CSA program staff raised concerns that many case managers lack sufficient training to administer CAFAS and complete it solely because it is required. Results of the CSA coordinator survey affirmed this point: 53 percent of CSA coordinators reported fewer than half of case managers had received CAFAS training within the past three years. Additionally, nearly all (93 percent) agreed that program staff generally only complete CAFAS because it is required and, consequently, may not devote the time necessary to ensure that scores reported are valid. In light of these and other concerns, OCS staff and CSA stakeholders are currently considering replacing CAFAS with another instrument.

In addition, it appears that CAFAS is either not performed or the score is not reported for a large number of children. Scores were missing for 11 percent of children who began receiving services on or after July 1, 2004. Only one score was available for another 49 percent of children, making it impossible to track changes in their level of dysfunction. Lack of CAFAS scores was also reported to hinder the ability of the State and local programs to conduct utilization management reviews, a process that is discussed in Chapter 7.

Recommendation (10). The Office of Comprehensive Services (OCS) and local CSA programs should coordinate regular and more frequent training to ensure that staff who evaluate children with standardized assessment instruments achieve accurate assessments. OCS should check the completeness of assessment scores reported and proactively

notify localities in which scores are missing for a substantial number of children.

In addition, information on the types of services provided to CSA children could be used to determine how many children are served in their homes, schools, and communities, and for those who must receive residential care, whether they return to their communities. While this information appears to be generally accurate, it only includes CSA-funded services and does not include information on services for which Title IV-E, Medicaid, or other sources of funding are used. Consequently, analysis of services in the CSA dataset alone will not reveal a complete picture of services received. For example, a child could receive counseling that is funded by CSA pool money, but concurrently reside in a group home paid for with Medicaid or Title IV-E funding. In this situation, the CSA dataset would only indicate that the child is receiving services in the community. A detailed discussion of this issue and potential solutions are presented in Chapter 4.

In addition, there is no indication of whether changes in the restrictiveness or intensity of services are the result of an improvement in a child's condition, and consequently a positive outcome. For example, the previous placement could have been too restrictive or intensive; thus, the change in placement reflects a more appropriate placement rather than child improvement. To address this issue, a field capturing the reason why services ended could be added to the CSA child-level dataset. This would assist State and local stakeholders in determining the extent to which children are changing services due to improvements rather than changes in service plan strategy. Moreover, this information could be used to determine why children are leaving the CSA program. For example, many CSA stakeholders have expressed concern that children may be aging out of the program rather than discontinuing services because their problems have been addressed.

Capturing this new field would require changes to State and local information systems, and would also necessitate local staff time to fulfill this additional reporting requirement. OCS should develop an estimate of the statewide cost of implementing this change by obtaining the input of all affected localities.

Recommendation (11). The Office of Comprehensive Services should consider including a field in its child-level dataset to indicate under what circumstances children are ending each service and exiting the CSA program in order to better measure child outcomes at the State and local levels. The Office of Comprehensive Services should report to the legislative joint subcommittee studying the Comprehensive Services Act on the financial and staffing resources needed to add an additional field to the child-level dataset.

MAJORITY OF CHILDREN APPEAR TO IMPROVE, BUT MANY STILL DO NOT PROGRESS

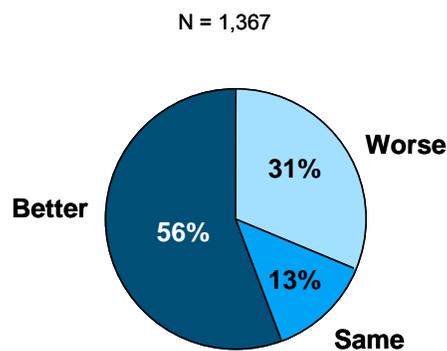
JLARC staff used three methods to characterize whether children's problems improved after receiving residential services: (1) analyses of changes in CAFAS scores over time, (2) analyses of changes in the restrictiveness of services over time, and (3) a survey of children's case managers. These three measures show mixed results about the frequency with which children appear to improve.

Majority of Children Appear to Improve Based on CAFAS Scores, but Some Are Getting Worse

Analyses of CAFAS scores indicate that more children showed improvements rather than deterioration in functioning after they received residential services funded through either CSA or Medicaid. JLARC staff compared CAFAS scores upon children's entrance to CSA with their most recent CAFAS scores. As shown in Figure 16, 56 percent of children who had received residential services were rated as doing better over time, but nearly one-third were doing worse, and 13 percent had not improved according to their CAFAS scores. Despite some concerns over their accuracy, CAFAS scores remain one of the few data sources available to measure child outcomes and are one means of characterizing the extent to which CSA participants improve over time.

Thirty-two percent of children exited the CSA program over the course of the time period, but this does not necessarily indicate

Figure 16: Although Majority of Children Showed Improvement in CAFAS Scores, Many Regressed



Months between first and most recent CAFAS = 8.8

Note: Children under the age of four, those for whom the assessment date was missing, and those with scores of zero on first and most recent CAFAS are excluded.

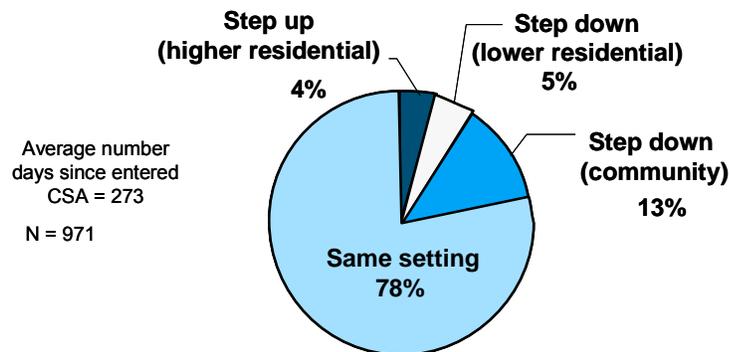
Source: JLARC staff analysis of CAFAS data in the CSA child-level datasets for FY 2005 through third quarter of FY 2006.

that the children's emotional and behavioral problems had improved. One-third of the children who left the CSA program after receiving residential services had worse CAFAS scores when they exited. Of those, fewer than ten percent were over the age of 18 and had seemingly exited the program solely because they were no longer eligible for services. This supports the recommendation that a data field recording the reason that children are exiting the program should be added to the CSA child-level dataset.

Most Children Continued to Receive Residential Care in the Same Type of Setting

Most children who began receiving CSA services on or after July 2004 and were initially placed in a residential setting were still receiving care in the same type of residential facility when they exited the CSA program or as of March 2006 for those still in CSA (Figure 17). Only 13 percent had returned to their community where they continued to receive CSA services, and five percent had stepped down to a less restrictive facility. However, a few (four percent) stepped up to a more restrictive type of facility.

Figure 17: Most Children Remained in the Same Residential Setting



Note: Services include those funded through CSA pool funds and Medicaid; Title IV-E funded services are excluded.

Source: JLARC staff analysis of CAFAS scores in CSA child-level datasets for FY 2005 through third quarter of FY 2006.

Case Managers Report that Problem Areas Improved for Majority of Children, but Issues Remain for Some

Most children who received residential care initially displayed problems involving physical fights, confrontations with others, or disruptive behavior in school. Results from the JLARC staff survey of case managers indicate that for the majority of children, these behaviors improved after receiving residential care (Table 20).

Table 20: Majority of Children Showed Improvements in Home and Community

	% of Children With Problem	Child's Reported Status in Problem Area After Receiving Residential Services (N=117)		
		Improved	Stayed Same	Worsened
Use of drugs/alcohol	34%	93%	3%	5%
Fighting	65	76	12	12
Cursing	62	69	22	8
Running away	37	79	0	21
Illegal activity	36	76	5	19

Note: Rows may not sum to 100 percent.

Source: JLARC staff analysis of CSA case manager survey results.

Case Manager Survey

JLARC staff surveyed case managers of a random sample of 240 children who received CSA-funded residential services between July 1 and December 31, 2005. The survey response rate was 49 percent.

Youths were especially likely to reduce their use of drugs and/or alcohol. In contrast, nearly one-quarter of children continued to be involved in fights at either the same level or more frequently than before they entered a residential program, and roughly 20 percent of children ran away or engaged in illegal activity more frequently than before they received residential services.

The majority of children improved their behavior, grades, and attendance at school since receiving residential services (Table 21). Children showed the greatest amount of improvement in attendance, but behavioral problems remained, at least periodically, for more than 30 percent of youths. In fact, 17 percent of children were suspended or expelled from school after receiving residential services primarily due to disruptive behavior in the classroom and fights with teachers or other students at school.

Table 21: Majority of Children Showed Improvements at School

	% of Children With Problem	Child's Reported Status in Problem Area After Receiving Residential Services (N=117)			
		Improved	Stayed Same	Worsened	Fluctuated
Behavior	66%	64%	18%	0%	13%
Grades	56	56	21	5	9
Attendance/truancy	35	73	12	5	5

Note: Rows may not sum to 100 percent.

Source: JLARC staff analysis of CSA case manager survey results.

A survey of case managers was conducted to gain additional information about the changes children have experienced in their home, school, and community environments, for which little centralized information is available, and because of the previously discussed shortcomings in CAFAS scores and services received. Surveying parents or guardians would have been preferable because they know their child best. However, it was not possible to

obtain accurate contact information, and many children in foster care did not return to the same foster family after their residential placement.

Local CSA Stakeholders Appear Satisfied With Effectiveness of Majority of Providers but Express Concerns About a Subset of Facilities

Local CSA program staff and case managers appear satisfied with the effectiveness of residential services offered by the majority of providers, but have concerns about some facilities. According to survey results, case managers reported residential services were effective for 73 percent of children in the sample of those who received residential services between July and December 2005. Case managers also indicated that residential providers did a good job in addressing most children’s specific behavioral, emotional, and educational problems, but providers were reportedly unable to address these issues for up to 14 percent of children (Table 22).

Table 22: Case Managers Believe Providers Do Good Job With Most Children in Problem Areas

Problem Area	Case Managers’ Perception of Whether Providers Do a Good Job		
	Yes	No	Don't Know
Behavior	84%	10%	6%
Mental health disorder	86	9	5
Social interactions	81	12	7
School	85	10	5
Life skills/independent living	76	14	10

Source: JLARC staff analysis of CSA case manager survey results.

The majority of CSA coordinators also reported sometimes having concerns about the effectiveness of residential facilities, but fewer than ten percent expressed being frequently concerned that facilities were: accepting children they are not equipped to serve, not providing the types of services expected by the CSA program, or not providing the quality of services expected by the CSA program. It is important to note that providers and local CSA staff alike cautioned that the best facilities may not always experience positive results with every child. According to them, a key to effectively providing services is for children to form good relationships with staff. Consequently, some children may do very well in a facility because this relationship is achieved, while others in the same facility may not.

These mixed findings are consistent with mixed results described in Chapter 2 regarding the ability of residential providers to keep children safe: while the majority of providers appear to offer quality services, some may lack the ability to provide effective services in a safe environment. These findings suggest the need to increase standards for the subset of providers who jeopardize the safety of residents and/or fail to help children progress and, consequently, undermine the State and localities' investment in the CSA program.

EFFECTIVENESS OF RESIDENTIAL SERVICES COULD BE STRENGTHENED THROUGH STRONGER STANDARDS, BETTER INFORMATION, AND GREATER ACCOUNTABILITY

Few mechanisms exist to facilitate the provision of effective residential services and hold providers accountable for their performance. Licensing standards may be too low to ensure that children receive the care they need from individuals who are well-qualified. Furthermore, little information exists to measure the extent to which individual facilities address children's needs. As a result, Virginia may not be consistently linking children with the providers best equipped to help them.

Improving Specificity and Scope of Certain Licensing Standards Could Improve Service Effectiveness

Many of the shortcomings in licensing standards that threaten children's safety may also limit the effectiveness of residential services. Based on a strong consensus among licensing specialists, a review of other states' and national standards, and the practices of Virginia providers, facilities that only meet Virginia's minimum requirements may not necessarily deliver effective services. In particular, current staff qualifications, training requirements, service plan development and implementation, and family participation are areas in which licensing standards should be strengthened in order to achieve more successful child outcomes and maximize Virginia's investment.

Providers Feel Qualifications Are Important

Over a third of providers rank qualifications of direct care staff and program directors among their top three factors in ensuring quality of residential services.

Staff Qualifications May Be Insufficient to Meet Children's Complex Needs. Licensing staff consistently reported concerns about Virginia's requirements regarding staff qualifications. Of particular concern are qualifications of direct care staff who interact with residents on a daily basis. Virginia standards only require that direct care staff have a high school degree or G.E.D. and "have demonstrated, through previous life and work experiences, an ability to maintain a stable environment and to provide guidance to children in the age range for which the child care worker will be responsible." Licensing specialists indicated that, at most, current qualifi-

cations allow for “custodial oversight rather than the individual and group therapy, counseling, and/or guidance most children in care require and that are the expectations reflected in the per diem rates.”

Fifty-two percent of direct care staff have only a high school degree.

According to results of the JLARC staff survey of residential providers, 52 percent of direct care staff have only a high school degree. Examples of some of the duties for which these direct care staff are responsible include

- reviewing applications and making admission decisions;
- contacting social workers, school staff, and family members;
- carrying out behavior management and interventions;
- ensuring school attendance, homework completion, personal hygiene, grocery shopping, meal preparation, house cleaning, and laundry activities;
- conducting psycho-educational groups regarding substance abuse avoidance, anger management, and social skills;
- providing transportation and recreational activities;
- administering medications; and
- applying physical restraints if necessary.

The Child Welfare League of America (CWLA) recommends that direct care staff have at least two years of post-high school education as well as experience in client management and counseling, recreation and therapeutic activities, behavioral intervention, client advocacy, and/or participation in the assessment and service planning process (Table 23).

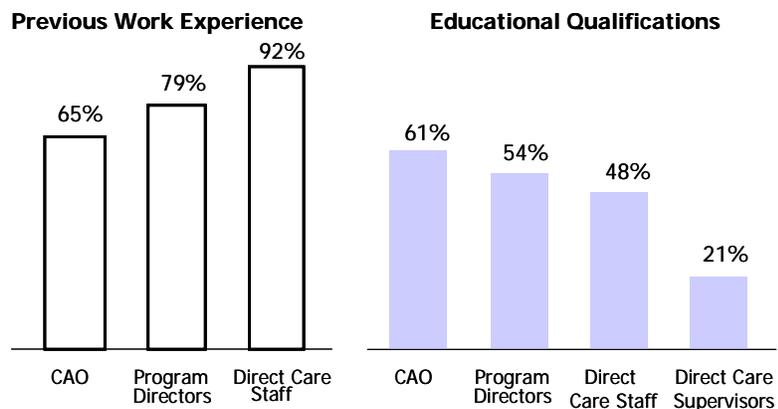
Table 23: CWLA-Recommended Qualification Requirements Exceed Virginia Standards

Position	Education Required by Virginia Standards	Education Required by CWLA
Chief Administrative Officer	Bachelor’s in human services or other Bachelor’s with two years of experience in human services	Graduate degree in human services, four years of administrative and supervisory experience in child welfare, with at least one year of experience in residential facility
Program Director	Graduate degree in child welfare or Bachelor’s degree with two years of experience in human services	Master’s degree in human services and experience in residential facility
Direct Care Supervisors	Bachelor’s in human services with two years of experience in human services or high school diploma/G.E.D. with five years of experience in human services	Master’s degree in human services and leadership training
Direct Care Staff	High school diploma/G.E.D. and life or work experience with children	High school diploma/G.E.D., two years post-high school education, and experience in human services

Source: JLARC staff analysis of CWLA Standards of Excellence for Residential Services.

CWLA also recommends higher educational degrees and/or greater experience levels for all of the positions outlined in Virginia standards (Table 23). For example, Virginia standards do not require chief administrative officers (CAO) or program directors to have any previous experience in a residential facility, yet those staff oversee and guide the development of the programs and services offered by the facility. According to survey responses, the majority of facilities in Virginia meet CWLA recommendations for previous work experience for key positions, but fewer meet these recommendations for educational qualifications (Figure 18).

Figure 18: Percent of Staff in Each Position Who Meet CWLA Recommendations



Note: CWLA recommends at least two years of post-high school education for direct care staff. Because the graph depicts staff with a Bachelor's degree but not staff with Associate's degrees, the actual percent meeting CWLA recommendations could be higher.

Source: JLARC staff analysis of CWLA Standards of Excellence for Residential Services and provider survey results.

Agency staff also agree that facility owners need to have appropriate credentials, which are not addressed by current standards. Not only do owners typically design the program's policies and procedures, but they may also carry out duties and make decisions for which they may not be qualified. Amended regulations to address House Bill 577 passed by the 2006 Session of the General Assembly will require owners who do not meet the qualifications of CAO and program director to appoint qualified individuals to fill those roles. In practice, however, these regulations will not prevent owners from making substantive program decisions when qualified individuals are not on the premises.

Residential Facilities Rank Staff Training as Top Factor in Ensuring Effective Services. Staff training can be an important supplement to qualifications, particularly if they are minimal. Surveyed facilities ranked staff training as the most important factor in ensuring

Eighty-five percent of providers feel that more training for direct care staff would be a very effective approach in improving overall quality of residential services in Virginia.

the quality of residential services. Furthermore, 85 percent of facilities think that training of direct care staff would be a "very effective" approach to improving the overall quality of children's residential services in Virginia. Better training of direct care staff could also reduce staff turnover, resulting in greater continuity of services and the opportunity for staff to develop skills through experience.

Licensing Standards May Not Adequately Address Provision of Case Management Services. Case management is an essential function for ensuring that appropriate services are identified and implemented to meet children's emotional and behavioral problems. Yet, Virginia standards do not outline qualifications that staff should possess in order to implement service plans and specify only that they should be supervised by staff who have either a bachelor's degree in a related human service field or two years related experience. As a result, direct care staff may conduct case management in addition to the other responsibilities described in the previous section.

Results of the JLARC staff survey of residential providers indicated that

- 40 percent of facilities have in-house case managers who are not licensed clinicians,
- 28 percent of facilities have case managers who provide counseling services even though they are not licensed clinicians, and
- 17 percent of case managers who provide counseling have only a high school degree.

In contrast, CWLA recommends that case managers have either a master's degree or a bachelor's degree with field experience in order to marshal "the diverse health, mental health, social service, educational, and employment resources necessary for children" receiving residential care. In addition, five out of eight neighboring states also require staff who implement children's service plans to have at least a bachelor's degree in a human service field.

Furthermore, CWLA recommends that facilities have at least one case manager on duty for every six or eight children (depending on the program). Roughly one-third of surveyed facilities in Virginia meet CWLA's recommended ratios for case managers. However, 56 percent of facilities report having no case managers on duty during the daytime, and 14 percent of surveyed facilities report having no in-house staff or contracted clinicians to provide this service.

Individualized Service Plans

Service plans outline appropriate services and interventions for a resident based on a careful assessment of the resident's needs and strengths. They also establish appropriate goals and time frames for reaching them.

Service Plans May Not Be Developed by Sufficiently Qualified Staff.

The quality of individualized service plans is affected if they are not developed by qualified staff, yet Virginia standards do not identify which facility staff should participate in their development. Rather, standards specify only that service plans should be developed by a team which includes the resident, resident's family or legal guardian, placing agency, and facility staff. Service plans that are not developed by qualified staff could jeopardize facilities' ability to address the emotional and behavioral problems of its residents. Inadequate service plans may fail to identify residents' most pressing needs, establish suitable goals, and outline effective strategies to achieve desired outcomes.

Licensing specialists reported that service plans are often poorly written by facility staff. Moreover, one specialist explained that the content is often "an indicator for the overall effectiveness of the program." According to survey results, 15 percent of facilities do not develop service plans to address educational needs of residents, and 35 percent do not develop service plans to address recreational needs. Although most providers reported developing individualized goals to address a child's needs for behavior support and intervention, six percent reported that they do not address this key element in their service plans.

Licensing specialists uniformly reported that staff with a master's degree or clinical background should participate in developing service plans, as well as direct care staff. Currently, over half of facilities already require someone with a master's degree and someone with a clinical background to participate in service planning, and over two-thirds require one or the other, even though standards do not compel them to do so. However, 22 percent of facilities require neither.

Licensing Standards Should Address Family Engagement. A fundamental goal of the Comprehensive Services Act was to ensure that children receive family-focused services. CSA stakeholders and providers consistently reported that without family involvement, progress experienced in residential facilities may be undone upon children's return to their homes and communities. Although they are not required to do so, more than 80 percent of facilities surveyed by JLARC staff develop written policies for working with and communicating with families and 69 percent contract for family counseling services. A much smaller proportion involve families in daily living programs (38 percent) and parent training or education (31 percent).

Recommendation (12). The boards of the four agencies regulating children’s residential facilities should direct agency staff to develop additional proposed regulations that address the findings from this report regarding the need for stronger standards governing the operation of residential facilities which are not addressed by the currently drafted proposed regulations. These additional proposed regulations should address the provision of case management services, development of service plans, and engagement of families in children’s services.

Child Outcomes Should Be Tracked to Assess Effectiveness of Residential Services

In addition to using regulatory means, the State could better hold providers accountable for delivering effective services by collecting better information. Most residential providers (61 percent) report that they already collect information on the outcomes experienced by their residents as a way to evaluate and improve the effectiveness of their services. However, not only is this information not consistently communicated to local CSA programs, but providers track outcomes differently, which makes a comparison of outcomes across providers difficult. In addition, a number of localities have created consumer satisfaction surveys as a way of measuring program effectiveness, and some have also undertaken their own initiatives to track outcome information. In a survey administered to local CSA coordinators, 15 programs reported that they have conducted a focused review of children’s outcomes. Although these measures may be useful to individual localities given the shortage of statewide information on children’s outcomes, it results in duplicative and inefficient uses of limited program resources.

To measure child outcomes, one or both of the following approaches could be followed. First, each locality’s contract could require residential providers to report performance on a specific set of outcome measures. Second, outcomes could be measured based on the information contained in the child-level dataset maintained by OCS. To implement the latter, a field would need to be added to the dataset to capture the specific facility in which a child is placed. Currently, the dataset only captures whether children are placed in a group home, residential treatment facility, or psychiatric hospital without specifying which one. OCS staff reported wanting to include provider numbers in the dataset for children receiving residential services which would make this linkage possible.

Recommendation (13). The Office of Comprehensive Services (OCS) should update the standard contract for residential services to include requirements for providers to (1) report and update information about their services on a quarterly basis, and (2) track and report performance on a standard set of child outcome measures. OCS should require localities that have developed their own contract to also add these requirements. In addition, OCS should validate the accuracy of the information submitted by private providers.

Recommendation (14). The Office of Comprehensive Services (OCS) should consider including a field in its child-level dataset identifying the facility in which each child has received residential care in order to determine each facility's effectiveness. OCS should report to the legislative joint subcommittee studying the Comprehensive Services Act on the financial and staffing resources needed to add an additional field to the child-level dataset.

Residential Expenditures and Overall Program Spending

In Summary

CSA program spending has been increasing at a slower pace in recent years, and federal funding pays for a larger share of services. Much of the State's fiscal oversight has centered around pool funding and should be broadened to include federal funding streams in order to better understand and control Virginia's investment in the CSA program. Because residential services comprise the majority of program spending, better managed spending on residential care could have the largest impact on overall program cost. During the last year, residential expenditures rose in large part because more children enrolled in the program, and the cost to serve those who needed residential care increased. However, residential services were of shorter durations, more heavily funded by federal dollars, and not as common as in the prior year. Looking ahead at ways to further control program spending, the greatest savings would be realized by ensuring that children receive residential services only when needed and helping staff manage the type, duration, and cost of necessary residential services.

CSA program expenditures have been growing at a slower pace in recent years. However, increasing service provider rates coupled with a larger caseload continue to result in higher program expenditures, prompting the State and local governments to seek solutions for further controlling cost. Because residential services are by far the most costly, mechanisms that seek to manage residential expenditures will likely yield the largest savings.

TOTAL COST OF SERVICES PROVIDED TO CSA PARTICIPANTS STRETCHES BEYOND POOL FUNDING

The total cost of serving CSA participants includes not only pool expenditures (State and local-only funds) but also services funded through the Medicaid and Title IV-E programs, which comprise the majority of funding sources available for children with emotional and behavioral problems. When CSA was created, several funding sources historically used to provide services to at-risk youths were combined, as described in Chapter 1. However, not all possible funding streams could be aggregated into one pool of funds. In particular, federal rules prevent pooling certain federal funding streams, such as those associated with the Title IV-E program. Although these funds are managed outside of the CSA pool, they are routinely used to pay for the services received by children eligible for either or both of these programs. In fact, CSA pooled funds are supposed to be used as a last resort, according to local staff.

Research Methods

Financial analysis of CSA service expenditures was conducted using child-specific data maintained by the Office of Comprehensive Services and Medicaid claims data supplied by the Department of Medical Assistance Services for services rendered between July 1, 2004, and March 31, 2006.

Despite the State's use of federal funds to provide services to at-risk children, most of the focus on tracking CSA expenditures has been placed on managing the pool of funds and, to some extent, Medicaid spending on residential care and case management for children in treatment foster care. In contrast, there is no systematic reporting of the payments made through the Title IV-E program, even though the State pays for half of its cost. This approach does not present a complete picture of program spending and therefore makes it difficult to understand and control rising expenditures.

Considering only CSA pooled funds is misleading. For example, trends in pool expenditures alone suggest that program costs increased by 5 percent in 2005, whereas an examination of the growth in other funding streams reveals that spending grew by as much as 10 percent. Furthermore, it would be inaccurate to examine which factors are contributing to growing program costs by focusing only on pool funding because these factors most likely affect total costs, not only the State and local share of expenditures. The current approach of considering only pool funding limits transparency and prevents decision-makers from making informed choices about spending for at-risk youths and their families.

In order for the State to obtain a comprehensive view of the cost of the CSA program, all funding sources should be included when budgeting for and reporting on the cost of the CSA program. At a minimum, the services funded through the Medicaid and Title IV-E programs should be captured for all children who also receive pool-funded services.

Recommendation (15). The General Assembly may wish to consider requiring the Office of Comprehensive Services to report all expenditures associated with serving children who receive pool-funded services. These expenditures should include the cost of (1) all services purchased with pool funding; (2) treatment foster care case management and residential care funded by Medicaid; and (3) child-specific payments made through the Title IV-E program. In addition, budget language should be included under each of the respective agencies identifying Medicaid and Title IV-E funding streams used to provide services for children who also receive pool-funded services.

The CSA State Executive Council (SEC) should also decide whether to include within the scope of the CSA program strictly these children who receive pool-funded services, or expand the population to include all children with emotional and behavioral problems that must be addressed by multiple agencies, which was the original construct of CSA. For example, children in foster care who receive services entirely through the Title IV-E program would not be part of the narrower CSA population because they re-

ceive no pool-funded services; yet, these children may in all other respects be very similar to other foster care children who are not IV-E eligible and, consequently, receive services through pool funds. In addition, the SEC should consider whether to track other funding streams, such as Mental Health Initiatives or Virginia Juvenile Community Crime Control Act (VJCCCA) funds, that are used to purchase services for children with emotional or behavioral problems.

Recommendation (16). The State Executive Council (SEC) should determine whether to track, report, and analyze the expenditures associated with children who do not receive pool funding but also have emotional and behavioral problems. In addition, the SEC should decide whether to track funding streams used to purchase services in addition to pooled, Medicaid, and Title IV-E funding.

RESIDENTIAL SERVICES ACCOUNT FOR LARGEST PORTION OF CSA PROGRAM EXPENDITURES

The cost of CSA services has been increasing consistently although at a slower pace since 2003. In addition, an increasing portion of care is funded through federal programs. However, the State still supplies the majority of funding, and the average cost of serving a child is rising each year. Of all the categories of services available to CSA participants, residential care comprises the majority of program spending. Although only one-quarter of CSA participants receive residential services, this type of care is about four times as expensive as services offered in the community, on average.

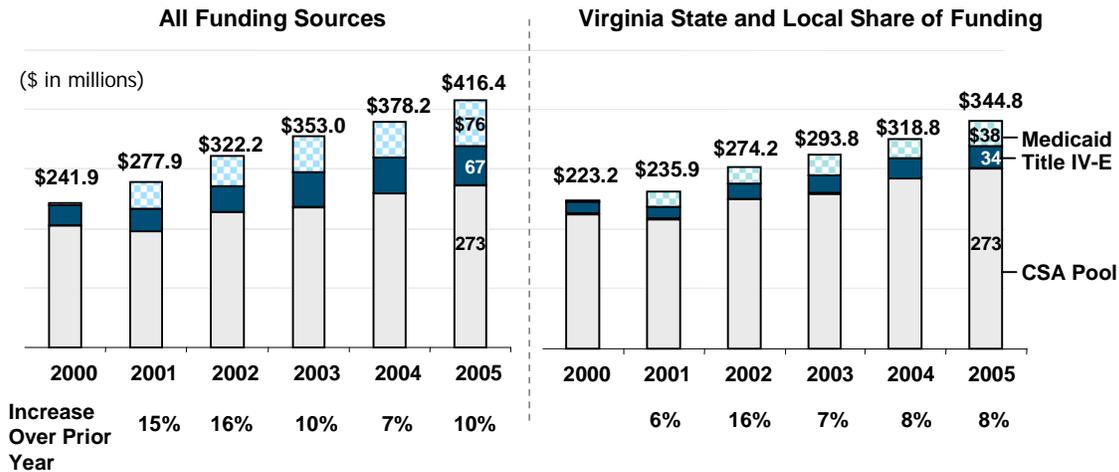
Although only one-quarter of CSA participants receive residential services, this type of care is about four times as expensive as services offered in the community, on average.

Expenditures Growing at Slower Pace, but Still Increasing

When the largest funding streams for services provided to children with emotional and behavioral problems are included, the cost of serving at-risk and troubled children totaled \$416 million in FY 2005, up 72 percent from 2000 (Figure 19). As described in Chapter 1, not all children who receive services funded through the Title IV-E program are eligible for CSA pool funding. However, because it is not known how much of this funding stream is used for children who are CSA-eligible, the total expenditures for this program is included in the analysis for illustration.

The rate of increase in expenditures has slowed since 2003 and is now around ten percent per year. Of all funding streams, CSA pool expenditures have grown at the slowest pace. In contrast, funding from federal programs has risen substantially. In particular, the use of Medicaid funding increased from \$5 million in 2000 to \$76 million in 2005. Despite higher utilization of federal funding, the

Figure 19: Federal Programs Funding Growing

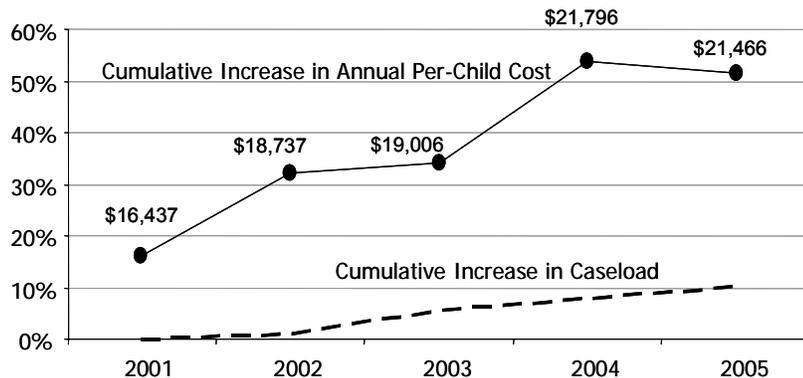


Source: JLARC staff analysis of financial data supplied by the Office of Comprehensive Services and the Departments of Medical Assistance Services and Social Services.

State and local governments are still paying for 83 percent of the total cost of CSA services.

The CSA caseload has grown by more than ten percent between 2000 and 2005. However, the rate of growth in expenditures has consistently been greater than the pace at which caseload has increased (Figure 20). This trend suggests that program expenditures are increasing primarily because the cost of services has increased and to a lesser extent because more children are served.

Figure 20: Per-Child Expenditures Growing Faster than Caseload



Note: Actual 2004 caseload is not available and was estimated.

Source: Expenditures and census data from the Office of Comprehensive Services.

Residential Services Are Largest Source of Expenditures

Since the program's inception in 1992, residential services have consistently accounted for the majority of CSA program expenditures. In 2006, at least 54 percent of program spending was incurred in residential facilities even though only 25 percent of children received this type of service. This disparity exists because residential care tends to be much more expensive than community-based services.

State Should Track How IV-E Funding Is Spent. It is critical for all funding streams to be considered in order to accurately describe trends in program spending. To conduct the analysis necessary to understand why such trends occur and how they can be controlled, access to detailed information about the specific services provided to children is also essential. In recognition of the fact that detailed information was needed for the State to better manage program expenditures, localities began reporting child-level information on services and expenditures.

However, the scope of this reporting mechanism encompasses only services paid with pool funding. This level of detail is not available for IV-E expenditures, which are only tracked in the aggregate by the Virginia Department of Social Services (DSS). Detailed information about the specific services purchased and children served through this program is kept individually by each local department of social services. However, a new system is being implemented that would enable DSS to track more detailed information at the State level. While services funded through Medicaid are tracked centrally by the Department of Medical Assistance Services (DMAS), there is currently no process to share detailed information with OCS.

Because there is no single centralized source of information about how Title IV-E funds are used, the State cannot assess how much is spent per CSA participant on certain types of services.

Because there is no single centralized source of information about how these funds are used, the State cannot assess how much is spent per CSA participant on certain types of services. This lack of comprehensive information makes it impossible to determine the true cost of specific services, the extent to which service costs change over time, and the reasons why such changes occur. Absent information on the root causes of changes in expenditures, cost control mechanisms and strategies cannot be effectively developed.

To access this information, one of two options could be used. First, the State could build upon the existing process through which localities report to OCS the services funded by pool money. Local CSA staff could be required to expand the scope of their reporting process to include the nature, timing, and cost of services funded in whole or in part by federal programs. This approach presents the advantage of obtaining all information in a consistent manner and

format: as a result, the quality of the dataset and its analyses is more likely to be accurate than if different data sources were merged. To implement this option, information systems at the State and local levels would have to be modified, and the scope of local staff's administrative activities would increase.

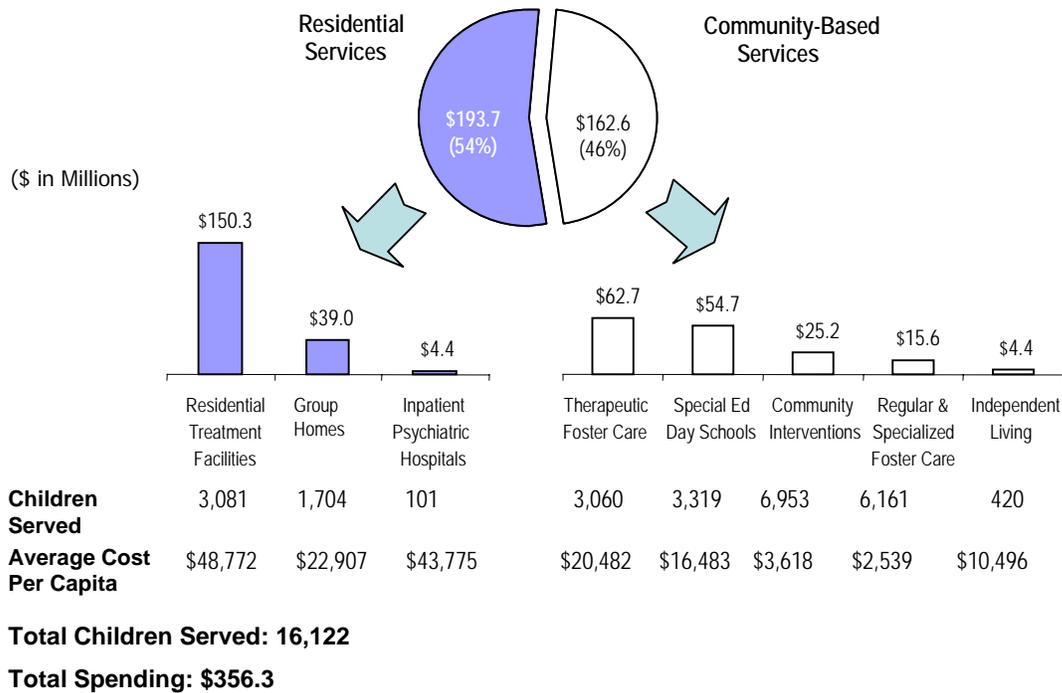
Alternatively, information could be obtained directly from DMAS and DSS and merged with data contained in the CSA dataset. While this approach would be more efficient, the result may not be as accurate because of the inherent difficulty in matching information generated by different systems. This matching process is also time-consuming and expensive. If information from different systems is conflicting, then information must be disregarded, which would cause expenditures to be understated, or assumptions must be made, which could negatively impact accuracy. In light of these considerations, a detailed cost-benefit analysis should be conducted to determine which approach is most desirable.

Recommendation (17). The Office of Comprehensive Services (OCS), in partnership with the Departments of Social Services and Medical Assistance Services and any other relevant agency, should obtain information on the nature and cost of services provided to the population of at-risk and troubled children identified by the State Executive Council as within the scope of the CSA program. OCS, in partnership with local CSA programs, should conduct a cost-benefit analysis of obtaining this information through either (1) local CSA programs or (2) the Departments of Social Services and Medical Assistance Services. OCS should use its findings to formulate a recommendation, which should be presented to the State Executive Council.

Majority of CSA Program Spending Occurs in Residential Facilities. Although most children are served in the community, the majority of CSA program expenditures are incurred in residential settings, primarily in residential treatment facilities which are also the most costly (Figure 21). The majority of spending on community-based services was for therapeutic foster care and related services and private day schools. However, the greatest number of children who are served in the community includes those served in their home and in a regular or specialized foster family.

Even though residential services are not as commonly utilized, they account for a greater share of program expenditures because they usually cost more than services provided in the community. On average, residential care is four times as costly as community-based services, in part because they are generally reserved for children with more complex needs. Residential treatment facilities provide the most costly services, and they are also the most frequently used by children in need of residential care. Among com-

Figure 21: Majority of CSA Pool and Medicaid Expenditures for Residential Services During FY 2005



Note: Number of children served does not add to the program's total caseload because children can receive multiple services. Figures exclude expenditures and children served exclusively with Title IV-E and/or Adoption Assistance funding.

Source: JLARC staff analysis of OCS dataset for July 1, 2004, through June 30, 2005.

community-based services, therapeutic foster care and private day schools are the most costly, while regular and specialized foster care are the least expensive to provide.

Detailed Expenditures Only Recently Available

Limited information exists about the specific services on which CSA funding was spent prior to the implementation of a statewide database in 2004. Moreover, data reported during the first year after implementation appears incomplete and inaccurate. As a result, an analysis of changes in spending patterns could only be conducted between 2005 and 2006.

It is important to note that the cost of receiving residential care for one year is substantially higher than the average annual cost of residential services. This occurs because not all children remain in residential facilities for an entire year. When they do, the average total cost ranges from \$57,000 for group homes to \$150,000 for psychiatric hospitals. As of March 31, 2006, 48 percent of children in residential care had been in a facility for 12 consecutive months or more.

SPENDING INCREASES FOR RESIDENTIAL SERVICES DRIVEN LARGELY BY PROGRAM CASELOAD AND RATES

Because residential care is the most expensive, controlling spending on residential services could help curb the rise in overall program spending. During the past year, growing residential expenditures have been driven in large part by a larger CSA caseload and

higher rates charged by residential facilities. However, the full extent of this growth has been mitigated by a shorter average length of stay and lower utilization of residential services. Due to data limitations discussed previously, this analysis excludes services funded through the IV-E program, which account for 16 percent of the cost of serving troubled and at-risk children.

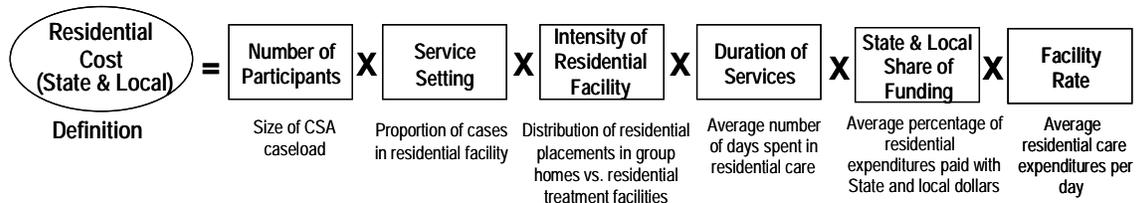
As illustrated in Figure 22, the overall cost of residential services to Virginia is a function of program caseload, utilization of residential care, intensity of residential settings used, duration of service, facility rate, and portion paid with State or local dollars. If the cost of any of these factors increases, so will the total cost of residential care. To understand how residential expenditures can be controlled, it is critical to first understand the extent to which each factor affects the cost of residential services in Virginia.

CSA residential expenditures increased by \$2.5 million, from \$126.5 million for the first nine months of 2005 to \$129 million during the same period in 2006. Two million dollars of this amount was paid by the State and local governments. This increase was driven by a rising CSA caseload, higher facility rates, and a greater use of higher-intensity residential treatment facilities (Figure 23). However, trends in several areas offset some of this increase. First, children spent less time in residential settings, on average. Second, federal funding paid for a greater share of residential services delivered in Medicaid-certified facilities. Finally, utilization of residential services declined.

Higher Caseload Driven Largely by Population and Child Characteristics

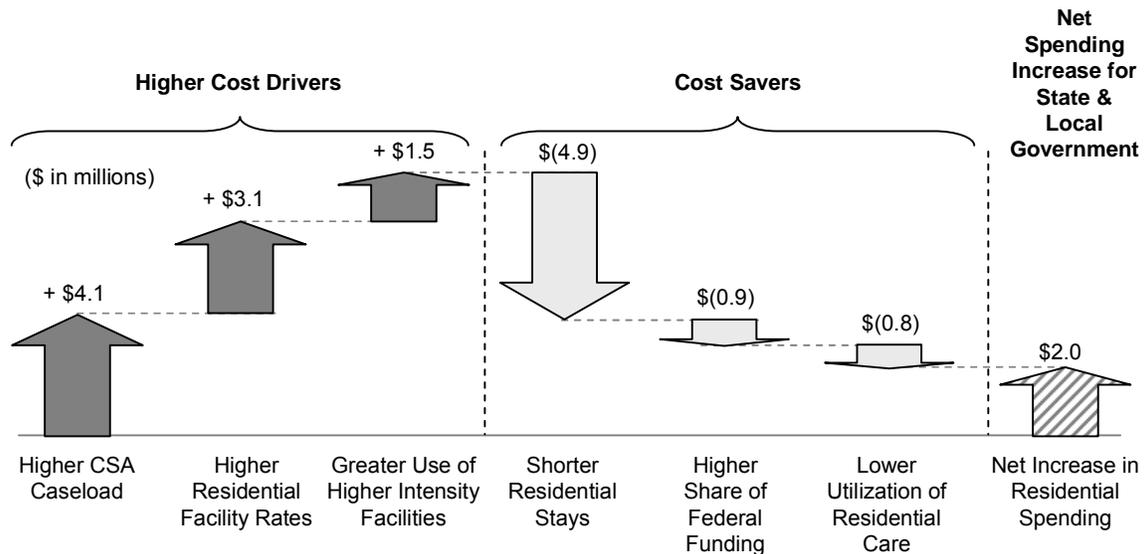
Between 2005 and 2006, residential expenditures grew in large part because more children entered the CSA program. Caseload increased by four percent during this period. Holding all other factors equal, this increase in caseload cost Virginia more than \$4 million during the first nine months of 2006.

Figure 22: Residential Care Spending Affected by Multiple Factors



Source: JLARC staff interviews with CSA stakeholders.

Figure 23: Shorter Residential Stays Helped Offset Fiscal Impact to State and Local Governments of Higher Caseload and Rates



Source: JLARC staff analysis of OCS dataset and claims data from the Department of Medical Assistance Services for the first nine months of FY 2006.

Nearly all (91 percent) of the variation in a locality’s caseload can be explained by a few characteristics of that locality’s population. Specifically, localities that are more populous and have a higher number of Food Stamp recipients, foster care cases, and Child Protective Services investigations also have a higher CSA caseload. Because of the sum-sufficient nature of the CSA program, children who are mandated for services cannot be turned away, making it difficult to control caseload.

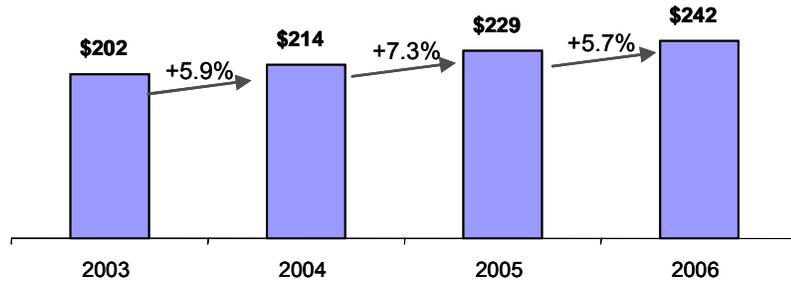
Rising Facility Rates Generally Appear Associated With Higher Cost of Doing Business

The average daily rate charged by residential facilities has increased by about six percent annually between 2003 and 2006, from \$202 to \$242 (Figure 24). In 2006, the increase in residential rates was slightly lower than in previous years, averaging 5.7 percent. Although this increase exceeds the general rate of inflation by only 1.9 percentage points, it caused program spending to increase by \$3.1 million during the first nine months of 2006. However, rate increases generally appear to reflect the higher cost of doing business faced by residential providers.

Nearly two-thirds of residential facilities that participated in the JLARC survey of residential providers increased their rates between 2005 and 2006.

Residential Treatment Facilities Increased Rates Most Frequently and Significantly. Nearly two-thirds of residential facilities that participated in the JLARC survey of residential providers in-

Figure 24: Average Residential Daily Rates Rising Steadily



Source: JLARC staff analysis of provider survey results.

creased their rates between 2005 and 2006. Among facilities that raised rates, the increase averaged 8.7 percent, ranging from a minimum of 1.5 percent to a maximum of 42.9 percent above 2005 levels. Residential treatment facilities were more likely to increase rates than group homes, and the magnitude of their rate increases was also higher (Table 24).

A review of rate changes since 2003 suggests that residential treatment facilities were consistently more likely than group homes to increase rates over time (Table 25). In fact, most residential treatment facilities raised rates at least twice during the three-year period, and all Medicaid-certified residential treatment facilities increased rates each year between 2004 and 2006. In contrast, a quarter of group homes has not increased rates since 2003.

Facilities Appear to Increase Rates to Meet Expenses and Mitigate Financial Losses. Most facilities that increased rates in 2004 appear to have done so because they were attempting to keep pace with rising expenses or had lost money in the previous year. In addition, facilities that increased their rates in 2004 had a higher average occupancy rate than facilities that did not raise rates (Table 26).

Financial Analysis of Residential Facilities

Results discussed in this section are based on an analysis of the 2004 and 2005 financial statements of residential providers who responded to a JLARC staff survey. Final 2006 financial statements were not yet available. This information was self-reported by providers and is not audited.

Table 24: Two-Thirds of Facilities Increased Rates in 2006

	2006 Average Daily Rate	% of Facilities with Rate Increase (2006)	Average Increase in Daily Rate
All facilities	\$242	65%	8.7%
Inpatient psychiatric facilities	\$484	80%	1.5%
Residential treatment facilities	\$290	86%	11.0%
Group homes	\$223	57%	7.0%
Shelters, wilderness programs	\$138	70%	4.6%

Source: JLARC staff analysis of JLARC provider survey results.

Table 25: Residential Treatment Facilities Increase Rates More Frequently

	% with No Rate Increase	% with 1 Rate Increase	% with 2 Rate Increases	% with 3 Rate Increases	Average Number of Rate Increases (2004-2006)
All Facilities	19%	26%	21%	34%	1.7
Group Homes	25%	30%	23%	23%	1.4
Residential Treatment	6%	17%	17%	61%	2.3

Source: JLARC staff analysis of JLARC provider survey results.

Table 26: Facilities With Rate Increases in 2004 Have Lower Profit Margins and Higher Occupancy Overall

	Facilities With Rate Increase in 2004			Facilities With No Rate Increase in 2004		
	Avg. Profit Margin ¹	% with Loss	% Occupancy	Avg. Profit Margin ¹	% with Loss	% Occupancy
All Facilities	7.1%	45%	79%	13.6%	41%	74%
Group Homes	7.1%	47%	78%	14.4%	38%	74%
Residential Treatment	7.0%	43%	80%	8.9%	50%	73%

¹ Average Revenue over Expenses as percentage of Total Revenues among facilities that had a positive profit margin in 2004.

Source: JLARC staff analysis of JLARC provider survey results.

Although the majority (55 percent) of facilities that increased rates had not experienced a loss in the previous fiscal year, their profit margins were significantly lower than facilities that chose not to increase rates (Table 26). As a result, these facilities may not have been in as strong a position to absorb higher program expenditures in the following year without a corresponding increase in revenues.

After raising rates, most of these facilities (75 percent) maintained or reduced their profit margin in the year following the rate increase, suggesting that the incremental revenues generated through higher rates were used to offset higher costs of doing business in these facilities. However, one-quarter of facilities further enhanced their profitability after raising rates. On average, these facilities realized a profit margin of 13.0 percent in the year after they raised rates, compared to 5.5 percent in the prior year.

One-quarter of facilities further enhanced their profitability after raising rates.

Residential providers cited greater competition for securing and retaining staff and the higher cost of employee benefits as the two most significant factors explaining their rate increases. This explanation is consistent with an analysis of their 2004 and 2005 financial statements, which revealed that rising expenses were driven largely by higher employee benefits, purchased services, and insurance costs, and did not appear concentrated among discretionary items such as administrative compensation. Higher profitability targets were the factor most frequently reported by residential providers as having no impact on rate increases.

In addition, a greater proportion of facilities that increased their rates had incurred a financial loss in the previous year than did residential providers that kept rates unchanged. Forty-five percent of facilities that raised rates in 2004 had lost money in the previous fiscal year. Of those, half restored profitability in 2005 and averaged a 4.3 percent margin of revenue over expenses. Despite charging higher rates, half of these providers remained unprofitable in 2005. This appears to have occurred because expenses grew at a faster pace than revenues. In particular, the increased cost of employee benefits, purchased resident services, rent/mortgage, and insurance outpaced the increase in rates.

Half of residential facilities that had incurred a loss in 2004 did not increase their rates during the following fiscal year, and most continued to generate a loss in 2005.

Surprisingly, half of residential facilities that had incurred a loss in 2004 did not increase their rates during the following fiscal year, and most continued to generate a loss in 2005. Furthermore, a quarter of these facilities did not raise their rates in either of the two subsequent years. This suggests that this group of facilities may be undercharging for their services.

Occupancy was the final distinction between facilities that raised rates and those that did not. Facilities that raised rates in 2004 also had a higher average occupancy rate. This suggests that occupancy may play a role in residential providers' decision to change rates, and that providers with higher occupancy may feel they have sufficient market power to command higher rates while other providers do not. A more detailed discussion of residential facilities' rates is included in Chapter 6.

Service Intensity of Facilities Used Is Shifting

Compared to 2005, a greater proportion of children who received residential care in 2006 were placed in residential treatment facilities than in group homes. Residential treatment facilities generally offer more intensive services than group homes and are, as a result, more costly. In 2006, residential treatment facilities charged an average of \$266 per day, compared to \$156 per day for group homes. At the same time, fewer children were placed in Medicaid-certified facilities, which tend to charge more than other facilities

(\$342 compared to \$182 per day, on average) because they typically have a larger and more highly qualified staff.

Shift in Referral Sources Linked to Greater Use of Residential Treatment Facilities. The shift toward greater use of residential treatment facilities appears to be associated with changes in the mix of referral sources. Specifically, a greater proportion of children were referred to CSA from local school systems, and these children more frequently receive care in residential treatment facilities than in group homes. Children referred from local schools more frequently suffer from emotional problems that generally appear to be addressed in residential treatment facilities. Furthermore, residential treatment facilities frequently have an on-site school that meets the educational needs of these children.

In addition, a smaller proportion of children were referred to CSA from the courts, and those children tend to be served in less restrictive residential environments such as group homes. Children referred to CSA from the court system more frequently exhibit issues that require behavior modification, such as truancy or oppositional defiance, which tend to be addressed in group home environments.

Reduction in Population with Mental Health Needs May Account for Lower Use of Medicaid-Certified Facilities. The number of children placed in Medicaid-certified facilities decreased between 2005 and 2006, resulting in a \$1.0 million decrease in the State and local portion of residential expenditures. This effect occurred because the average cost of Medicaid-certified facilities is higher than for other facilities, even after accounting for federal funding. In 2006, the average daily cost of care in a Medicaid-certified facility was \$342, of which 63 percent was paid with Virginia dollars. As a result, one day spent in a Medicaid-certified facility cost Virginia an average of \$215, compared to \$182 for other facilities.

State and local dollars account for 63 percent of spending in Medicaid-certified facilities because some residents lose Medicaid eligibility at some point during their stay.

Because federal dollars pay for half of Medicaid services, it should be expected that the State and local governments would pay for only 50 percent of the cost of residential services provided in Medicaid-certified facilities. In fact, State and local dollars account for 63 percent of spending in these facilities because some residents lose Medicaid eligibility during their stay. When this occurs, the State and local governments must pay for the entire cost of care. According to local CSA stakeholders, Medicaid eligibility can be difficult to establish and/or maintain. Furthermore, local staff indicated that the well-being of children takes precedence over cost: as a result, children remain in the same facility if it is best suited to address their needs, even after Medicaid stops funding their care.

The use of Medicaid-certified facilities appears to be associated with the proportion of children who have been diagnosed with a mental health condition and those who take psychotropic medications. To be admitted into a Medicaid-certified residential facility, a child must generally suffer from mental health problems. The proportion of children with either of these characteristics decreased slightly between 2005 and 2006, and may partially explain why fewer children were placed in Medicaid-certified facilities.

Duration of Residential Stays Decreasing

The average duration of residential stays was four days shorter in 2006 than in 2005. Children remained in residential facilities for an average of 152 days during the first nine months of 2006, compared to 156 days for the same period in 2005. Because residential facilities usually charge a daily rate, this decreased length of stay reduced residential expenditures by \$4.9 million during the first nine months of 2006, compared to the same period in 2005. This trend may be linked to a decrease in the average age of CSA participants and the proportion of children who take psychotropic medications because older children and those who take medications tend to receive residential services for longer periods.

Higher Utilization of Federal Funding in Medicaid-Certified Facilities Associated With Lower Virginia Spending

Federal funds accounted for a greater share of expenditures incurred in Medicaid-certified residential facilities in 2006, compared to the previous year. This modest increase of 1.3 percentage points resulted in savings of \$0.9 million to the State and localities. As discussed earlier, federal matching funds can only be used to pay for services while a child is eligible for Medicaid. As a result, Virginia's share of expenditures can only be minimized if children maintain eligibility longer or transition to a lower-intensity setting as rapidly as appropriate given their needs.

Smaller Proportion of Children Served in Residential Environments

The proportion of children who received residential care decreased by six percent between 2005 and 2006, resulting in reduced spending of \$0.8 million during the first nine months of 2006. The age of CSA participants is a factor closely associated with residential utilization, and the average age of children in the program decreased between 2005 and 2006. This change could explain part of the decrease in residential utilization since younger children are less likely to utilize residential services. In addition, local CSA stakeholders report a strong focus on minimizing residential place-

ments, which may also be resulting in lower utilization of residential services.

REDUCING RESIDENTIAL PLACEMENTS AND MANAGING RESIDENTIAL STAYS WOULD MAXIMIZE SAVINGS

While residential expenditures are driven in part by external factors such as rising caseload and changes in children’s needs, CSA stakeholders can take steps to mitigate external effects while ensuring that children receive the most appropriate yet least costly services available. In many cases, it appears that the same steps that would improve the effectiveness and appropriateness of services offered to CSA participants would also reduce costs. Based on an analysis of 2006 expenditures, the most effective means of reducing future program spending by managing residential costs include avoiding unnecessary residential placements, and when residential care is necessary, managing the type, duration, and daily cost of residential services (Table 27). Chapters 5 through 7 of this report provide evidence that improvements could be made in each of these areas, and include recommendations for addressing current shortcomings.

Table 27: Each One of These Changes Could Result in \$1 Million Savings

Options to Decrease Residential Expenditures	Magnitude of Change	Estimated Number of Children Impacted
Reduce utilization of residential services when unnecessary	0.2% decrease	34
Reduce usage of high-intensity residential services	1.3% decrease	62
Negotiate lower rates per day	\$1.53 decrease	All in residential
Increase use of federal funding	1.3% increase	All in Medicaid facilities
Reduce length of stay	0.8 day decrease	All in residential

Note: Based on experience during first nine months of FY 2006.

Source: JLARC staff analysis of OCS dataset and claims data from the Department of Medical Assistance Services.

Avoiding Unnecessary Residential Placements Would Yield Greatest Savings to the State

The most effective method of reducing residential expenditures is to decrease the frequency of residential placements for children who can safely and adequately be served in the community. Residential services are a critical component of the continuum of care available to children and should be made available to all who re-

quire this intensity of service. However, some savings opportunities may exist for children who are currently served in residential settings but whose level of need does not warrant this type of care. CSA stakeholders indicated that in the vast majority of cases, this occurs because the community-based services that would be better-suited to the child's needs are not available locally. A detailed discussion of this issue and potential solutions are included in Chapter 5.

CSA program costs could decrease by approximately \$1 million if only 34 children were served in the community instead of a residential facility. For every child who can successfully be served in the community, residential expenditures would be eliminated, and spending would be incurred instead for community-based services. On average, the annual cost of serving a child in the community is one-quarter of the cost of residential care (\$11,360 compared to \$48,129 in 2005).

Intensity, Rates, and Duration of Residential Services Could Be Better Managed

When children need residential care, certain aspects of their stay should be managed to minimize expenditures. When making placement decisions, referral sources should identify the least restrictive environment that is most appropriate for the child's needs. Furthermore, rates could be more effectively negotiated with residential providers and federal funding maximized whenever possible. Finally, children should be transitioned back to their community as rapidly as appropriate. However, JLARC staff visits to local CSA programs revealed multiple hurdles to following this process and securing the most cost-effective residential services.

Least Restrictive Placement Should Be Identified. Children should be served in the least restrictive residential setting that is appropriate to address their needs because it is not only consistent with program philosophy, but it is also less costly. If 1.3 percent of children who need residential care were served in group homes instead of residential treatment facilities, the State and local governments could save \$1 million annually. However, local program staff identified several obstacles to consistently securing the intensity of services needed.

Many communities identified the lack of group homes as a key service gap in their community, which has forced some children to remain in unduly restrictive residential treatment facilities. Moreover, local stakeholders have referenced the difficulty in properly assessing children's complex needs and promptly making placement decisions, particularly when they do not have access to local assessment resources (see Chapter 5). In addition, limited infor-

mation is available about the scope and nature of services available in each residential facility, which may cause children to be placed in a setting that does not best match their needs (see Chapter 6).

Finally, it is unclear whether the use of Medicaid-certified facilities has yielded significant savings to the State. Because some program costs were not available to analyze for this study, it is not possible to conclude with certainty whether using these facilities costs Virginia more or less. However, it appears that any potential savings are limited because Medicaid-certified facilities charge significantly more, and portions of a child's stay must sometimes be financed entirely with State and local dollars.

Despite the lack of a clear fiscal advantage to using these facilities, it is important to note that most local CSA stakeholders believe that Medicaid-certified facilities have contributed to the State's service array and are better able to serve certain CSA participants. Moreover, many local CSA staff indicated that these facilities tend to offer higher quality care. The improved effectiveness and quality of services provided in Medicaid-certified facilities should be weighed against the incremental cost when making placement decisions.

Negotiating Facility Rates Could Yield Significant Savings. The ability to negotiate a fair and consistent rate with residential providers could have a significant impact upon residential spending. Reducing the average daily residential rate by \$1.53 per day would have resulted in savings of \$1 million across the State in 2006. Residential rates were deregulated when CSA was established in 1992 because the expectation was that local purchasers of residential services would be in a position to negotiate rates based on information on the cost and scope of services provided by each facility. In practice, it appears that local negotiations frequently do not take place.

Eighty percent of local CSA staff that responded to a JLARC staff survey indicated being unsuccessful with negotiating lower rates. In particular, most localities reported not having much leverage over residential providers because they do not place a large enough number of children. In addition, local staff explained that children are often placed in residential facilities on an emergency basis, and that rate negotiations can hardly be conducted effectively under those circumstances. Finally, local case managers generally lack information about the cost and scope of services provided in facilities and cannot, as a result, consistently discern whether a facility's rates are justifiable (see Chapter 6).

Steps Should Be Taken to Maximize Federal Funding. Actively pursuing the availability of federal funding could defray part of the cost of residential care to the State and local governments. In particular, increasing by 1.3 percent the proportion of expenditures paid through Medicaid matching funds could yield savings of \$1 million per year for Virginia. Local CSA staff indicated that maintaining Medicaid eligibility can be difficult. In addition, some children may remain in Medicaid-certified facilities after they lose eligibility because adequate services are not available to support their transition back to the community. In both cases, it appears essential for local CSA staff to closely monitor the status of each child who has been placed in a Medicaid-certified facility to minimize the extent to which the State and localities are unnecessarily funding children in these facilities. This enhanced level of scrutiny could be provided through Utilization Management and Review efforts as well as through more focused reviews by local Family Assessment and Planning Teams (see Chapter 7). These efforts may be particularly important because the 2006 federal Deficit Reduction Act could reduce the availability of Medicaid funding to the State.

Children Should Promptly Transition Back to Their Communities. CSA stakeholders interviewed for this study consistently reported that some children may remain in residential facilities longer than is necessary to address their needs. In addition to potential negative therapeutic effects, extended stays also come at a substantial cost. By reducing the average length of stay in residential facilities by less than one day, Virginia could save \$1 million annually. Local CSA staff explained that children may not be discharged if the proper services are not available to either prepare their families for reunification or to support them in a community setting (see Chapter 5). In addition, interviews with staff from 17 local CSA programs revealed the importance of developing comprehensive discharge plans early. This process could be facilitated by enhanced Utilization Management and Review efforts as well as through more focused FAPT reviews (see Chapter 7).

Evaluating Eligibility Could Have Limited Impact on Caseload and Expenditures

While the growing number of children being referred to the CSA program for services has a significant impact on program costs, little can be done to control caseload because most children are legally required to be served. The primary means of managing caseload is to ensure that eligibility criteria are properly interpreted and applied. Localities that experienced an increase in caseload between 2005 and 2006 tended to have a growing share of foster care prevention cases. As described in Chapter 1, children are mandated for services under the foster care prevention cate-

gory if they are at risk of being removed from their home. According to local CSA staff, the criteria defining eligibility for this category are vague. As a result, localities' caseload may be impacted by their interpretation of foster care prevention (see Chapter 7).

Gaps in Services for Children Limit Cost Effectiveness of CSA Program

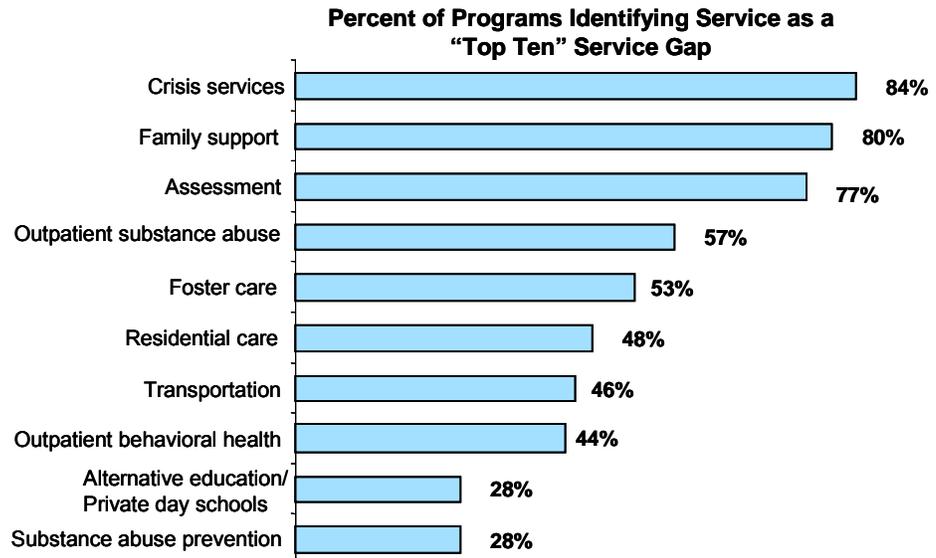
In Summary

Gaps in the availability of services for at-risk children and their families create unnecessary costs, jeopardize children's ability to improve, and undermine the core objectives of the CSA. Service gaps appear to prevent many local CSA programs from connecting some children with the most appropriate services to meet their emotional or behavioral needs. As a result, children commonly receive services that are overly intensive and expensive. In some cases, children must move away from their families to other parts of the State or the locality to access services that are not available locally. The availability of in-home and community-based services was cited as the biggest hurdle to maintaining children in their homes, schools, and communities. Furthermore, the insufficient supply of foster families appears to often preclude children from remaining in community-based settings, even when other services are available locally. Finally, disparities in the availability of residential care can lead to out-of-community placements and difficult transitions back to children's homes. To assist localities in providing children with the most appropriate and least costly services, a greater investment must be made in service development.

One of the most promising strategies for controlling CSA program expenditures is to reduce the utilization of residential care by improving access to community-based services for children who can safely and effectively be served in this setting. Based on interviews with and surveys of numerous CSA stakeholders statewide, it appears that the primary reason for children receiving services that are overly restrictive or intensive for their needs is a lack of more appropriate alternatives. In particular, gaps in the availability of several community-based services, foster families, and residential facilities preclude children from being served in and returning to their homes, schools, and communities (Figure 25).

These service gaps jeopardize children's ability to improve, contribute to escalating program costs, and prevent the State from achieving the CSA's core objectives of providing appropriate and cost-effective services. Addressing service gaps presents an uncommon opportunity to improve the quality of care offered to children while reducing program spending. Greater State financial investment along the entire spectrum of CSA services could alleviate the most critical service gaps, ensure that children and their families receive appropriate and cost-effective services, and facilitate the provision of services within or close to their own homes and communities.

Figure 25: Top Ten Service Gaps Identified by Local CSA Program Staff



Source: JLARC staff survey of local CSA Community Policy and Management Team chairpersons.

Research Methods

JLARC staff asked all local Community Policy and Management Team chairpersons to identify the top ten service gaps that prevent them from serving more children in their homes, schools, and communities, and to explain why these services are lacking. Seventy-two percent of localities responded to the survey.

JLARC staff also interviewed program staff in 17 different local CSA programs and surveyed all local programs about factors that impact service planning decisions and challenges staff experienced in connecting children with appropriate services. Eighty-five of 107 programs responded to the survey.

LIMITED AVAILABILITY OF SOME SERVICES HINDERS LOCAL CSA PROGRAMS FROM SECURING THE MOST APPROPRIATE AND COST-EFFECTIVE SERVICES

Gaps in the availability of services for at-risk youth and their families create unnecessary costs, jeopardize children's ability to improve, and undermine the original intent of the CSA. Service gaps appear to prevent many local CSA programs from connecting some children with the most appropriate services to meet their emotional or behavioral needs. Research suggests that in order for children to experience improvements in problems with their behavioral or mental health, the most appropriate services to meet their needs must be available and accessible. Yet, an inability to secure the most appropriate services for some children and their families appears to be an issue in most local CSA programs.

Of primary concern are instances in which children are placed in more restrictive care settings than necessary due to a lack of less restrictive or intensive alternatives, such as family-based foster care. As discussed in Chapter 4, services that are more intensive or that are delivered in more restrictive environments tend to be more costly than less intensive or restrictive alternatives. Therefore, in addition to having potentially detrimental consequences for children's already tenuous emotional and behavioral stability, service gaps can also cause the State and local governments to incur

unnecessary costs to serve CSA children. Finally, service gaps are the primary obstacle to fully realizing the original intent of the CSA, which states that troubled and at-risk children should receive "appropriate services in the least restrictive environment."

Service Gaps Sometimes Lead to Unnecessary Spending

Most of the CSA staff interviewed and surveyed by JLARC staff reported instances in which some CSA children receive services that are more intensive or restrictive than necessary to meet their behavioral or emotional needs. While local program staff identified several reasons for placing children in overly restrictive or intensive service settings, including poor identification of children's service needs, they most often cited a lack of community-based services or foster care families that could be used as alternatives. Nearly all survey respondents indicated that the lack of community-based services had a "high" or "moderate" impact on decisions to place children in overly intensive or restrictive service settings.

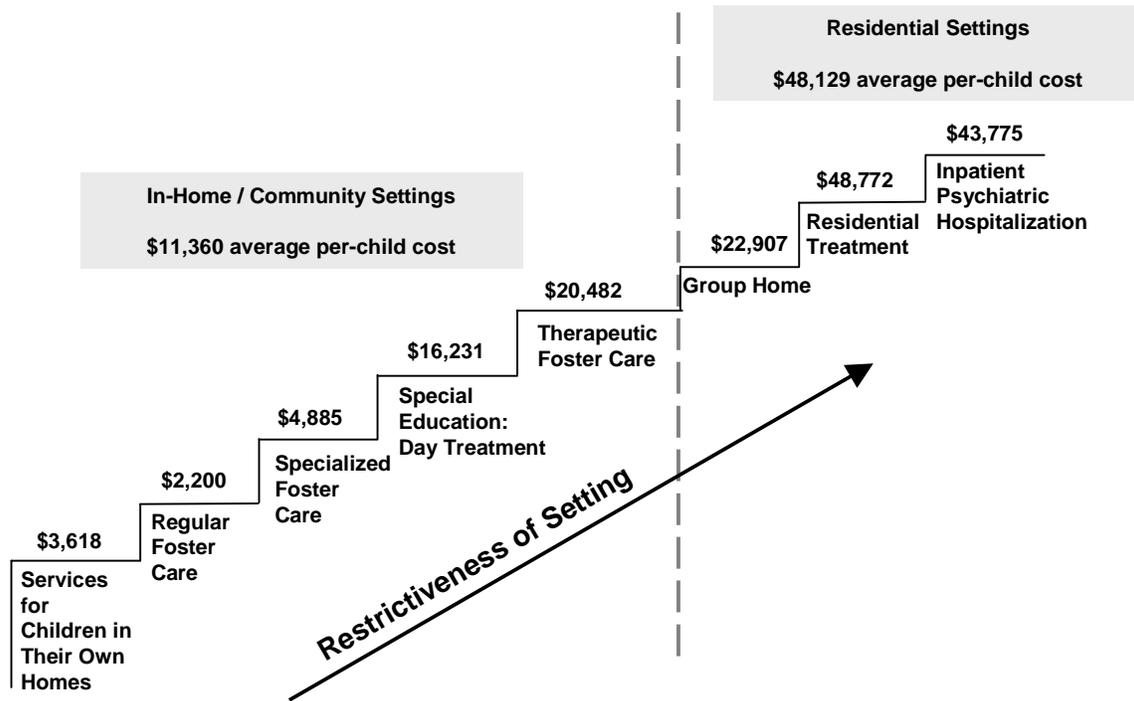
Most local programs reported having placed a child in an overly intensive or restrictive service in the past year, primarily due to a lack of community-based alternatives.

Service Gaps May Inflate Program Spending and Compromise Child Outcomes. Most local programs (62 percent) reported having placed a child in an overly intensive or restrictive service in the past year. The majority estimated that this occurred in fewer than 10 percent of all cases. However, more than one-third reported that 10 to 30 percent of children had received unnecessarily intensive or restrictive services and 11 percent indicated that this had occurred in up to half of all cases. To illustrate, FAPT members in the metro-Richmond area estimated that three-quarters of the children in group homes could be served in a therapeutic foster care (TFC) or regular foster family home if more foster families were available. Additionally, the CSA coordinator for one Northern Virginia locality estimated that three-quarters of the program's children currently in residential placements could be served in the community if community-based services were available.

As shown in Figure 26, it is more than four times as expensive to serve a child in a residential environment as in the community (average annual cost of \$48,129 per year versus \$11,360 per year in 2005). Consequently, serving even a seemingly low number of children in a setting that is overly restrictive can quickly escalate program costs. As a result, programs whose staff reported placing children in more intensive or restrictive services than necessary tend to have higher than average per-child expenditures and a higher proportion of children in residential care.

Connecting children with services that are not well matched to their needs can also impact children's experience with CSA services and lead to higher program costs over the long term. In fact, approximately two-thirds of localities reported that mismatched

Figure 26: Stepping Children Up to More Intensive or Restrictive Services Can Escalate Program Costs Substantially



Note: Average annual spending is based on actual period during which services were received and does not represent total cost of receiving services for a full year.

Source: JLARC staff analysis of FY 2005 client-level data provided by the Office of Comprehensive Services.

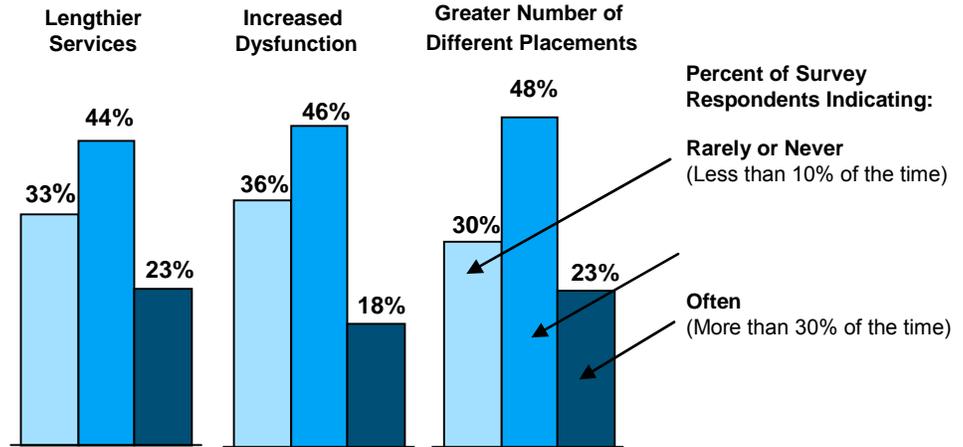
services "sometimes" or "often" result in increased length of stay in CSA services, an increased number of different placements, and increased levels of mental or behavioral dysfunction (Figure 27), all of which are associated with higher program costs.

Service gaps are not isolated to particular areas of the State, and actually appear to affect all regions. Eighty-four percent of local program staff responding to the JLARC staff survey reported having trouble finding appropriate community-based service providers within the past year, and nearly half of these reported that this occurs "frequently" or "almost always."

Service Gaps May Delay Some Children's Return to the Community.

Just as a lack of community-based services prevents some CSA children from receiving care in their communities when it is safe and appropriate, it also inhibits children's transition to community-based care from more restrictive environments. Half of all survey respondents, who represent all regions in Virginia, indicated that a lack of community-based providers has been an obstacle to transitioning children back to their home, school, or community. The following examples further illustrate these findings:

Figure 27: Mismatched Services Can Have Negative Consequences for Children



Source: JLARC staff analysis of responses to a survey of local CSA programs.

Case Studies

One Northern Virginia CSA coordinator reported that CSA children are kept in residential treatment facilities because there are not enough group homes available in that area to transition them to, and estimated that this is a "significant occurrence."

* * *

A Richmond-area CSA coordinator reported that most children who transition to a group home setting from a residential treatment facility will remain in the group home until they are adults because there are not enough services in the community to support them in a non-residential environment.

* * *

FAPT members in one western Virginia program estimated that three-quarters of their clients in residential care will remain in a residential facility for longer than necessary because of the lack of less restrictive alternatives.

Program costs will increase by an average of \$232 per day for every child whose residential stay is unduly extended.

Delaying a child's discharge from a residential facility also exacerbates program costs because of the higher cost of residential services. In fact, program costs will increase by an average of \$232 per day for every child whose residential stay is unduly extended.

Children's well-being may also be compromised—local programs report that the behavior problems of children who remain in residential care may worsen and children may become too "institutionalized" by their environments to ultimately function in a less structured community-based setting.

Service Gaps Undermine the Intent of the CSA. The primary purpose of the CSA is to ensure that children receive the most appropriate services to address their mental and behavioral health needs. It should be noted that JLARC staff did not examine the effectiveness of services delivered in the community versus a residential setting, but there is a general consensus among stakeholders interviewed by JLARC staff that residential placement can be the most appropriate service setting for some children. When gaps in service availability—either community-based or facility-based—result in children and their families settling for assistance that is not well matched to their needs, the CSA's objectives are not achieved. Moreover, children may not make as much progress as they could if more appropriate services were available, or their behavioral and mental health problems may worsen. According to case managers responding to a JLARC staff survey on outcomes experienced by CSA children, the availability of community-based services had an impact on the behaviors of many children after ending residential care.

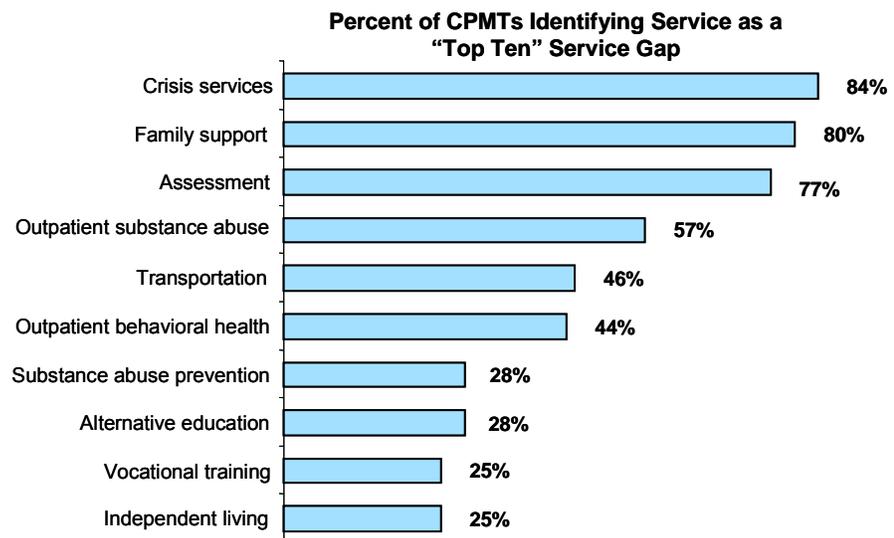
Research supports the notion that, in order to improve, children need access to the most appropriate services to meet their needs. According to a 2002 report to Congress by the U.S. Department of Health and Human Services, access to appropriate services facilitates children's ability to manage their problems. The report states that being able to access appropriate services "contributed significantly to improvements in [children's] behavioral and emotional problems." Additionally, the report indicated that children in communities where appropriate services were "highly accessible" experienced greater improvements than those in communities where appropriate services were "less accessible."

GAPS IN COMMUNITY-BASED SERVICES UNDERMINE CSA GOALS

The CSA emphasizes that children should receive services in the least restrictive service setting appropriate for their needs. While it appears that local CSA staff generally promote this philosophy, gaps in certain community-based services have resulted in some children not receiving the assistance they need and instead being placed in settings that are unnecessarily restrictive. CSA staff from most local programs reported having difficulty connecting children with a needed community-based service "frequently" or

"almost always" within the past year. In addition, local Community Policy and Management Team (CPMT) members responding to a service needs assessment survey conducted by JLARC staff most frequently cited in-home and community-based services as the primary service gaps for CSA children in their localities. In particular, CPMTs in all parts of the State reported a lack of crisis intervention, family support, and psychiatric assessment services for CSA children. The primary gaps in community-based services identified by CPMTs are shown in Figure 28.

Figure 28: Critical Community-Based Service Gaps Identified By Local CPMTs



Source: JLARC staff survey of CPMT chairpersons.

A lack of appropriate community-based services can result in children receiving care in overly restrictive service settings for two reasons:

- If the service is aimed at family preservation and bolstering the family's ability to function as a unit, the family structure may break down in the absence of this service and the child may be removed from the home. If the most appropriate service had been available, this scenario may have been prevented.
- Similar services can be offered by both community-based and facility-based providers. If local program staff determine that a community-based setting is appropriate for such a service, but the community-based providers are nonexistent or do not have the capacity to meet demand, the child may receive that service in a facility-based setting.

Crisis Services

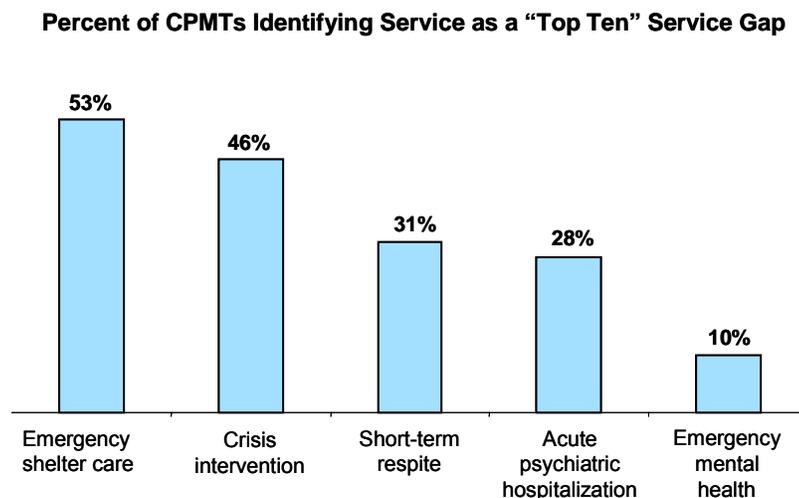
Crisis intervention and stabilization services are services to families in crisis who are at imminent risk of child maltreatment, or to youth in crisis who require services to stabilize them and avert hospitalization.

Emergency shelter care is temporary placement of a child in a shelter because of or to prevent maltreatment.

Community-Based Crisis Intervention Services Are Insufficiently Available Statewide

Eighty-four percent of CPMTs responding to a JLARC staff survey on local service gaps identified crisis services among the top ten critical service gaps in their communities. Crisis services include emergency shelter care, crisis intervention and stabilization services, emergency mental health services, acute psychiatric hospitalization, and temporary respite services. Emergency shelter care and crisis intervention services were the most often cited types of missing crisis services for CSA children and their families (Figure 29).

Figure 29: Services for Children and Families in Crisis Are Among Services Most Critically Lacking Across State



Source: JLARC staff survey of CPMT chairpersons.

Crisis intervention services are a critical component of the continuum of care for CSA children and their families because they are aimed at preventing child maltreatment. According to some local agency staff, when short-term crisis intervention services or emergency shelter care is not available for children who are at risk of abuse, children are likely to be placed in a residential facility instead, which may result in moving the child to another part of the State. While this may be an effective stop-gap measure to prevent child maltreatment, it results in unnecessarily restrictive placements and potentially further undermines family functioning if family-child interaction is limited. According to one CSA coordinator in Northern Virginia, if a short-term crisis stabilization service was available in that region, three-quarters of the program's residential placements could be avoided.

Family-Based Services

Parent and family mentoring involves individuals who assist parents and families in developing appropriate parenting and coping skills.

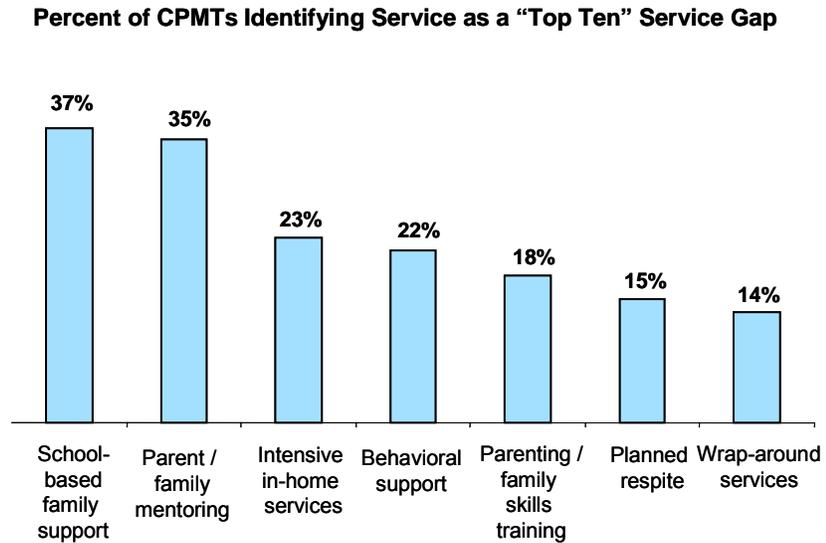
School-based family support is support provided to children and families by social workers stationed in the child's school.

Intensive in-home services are counseling and skills training services provided when children are at risk of removal from the home or are being transitioned back home.

Services to Support Family Preservation Are Lacking

In addition to crisis intervention, services aimed at helping families manage their children's needs are paramount to preserving family structure and to preventing children from being removed from their homes. Eighty percent of CPMTs responding to the JLARC staff's survey reported that family support services are among the top ten service gaps in their communities. In particular, parent and family mentoring, school-based family support, and intensive in-home services are the family-based services that CPMTs most often described as inaccessible in their communities (Figure 30).

Figure 30: Services to Preserve and Support Families Are Among Services Most Critically Lacking Across State



Source: JLARC staff survey of CPMT chairpersons.

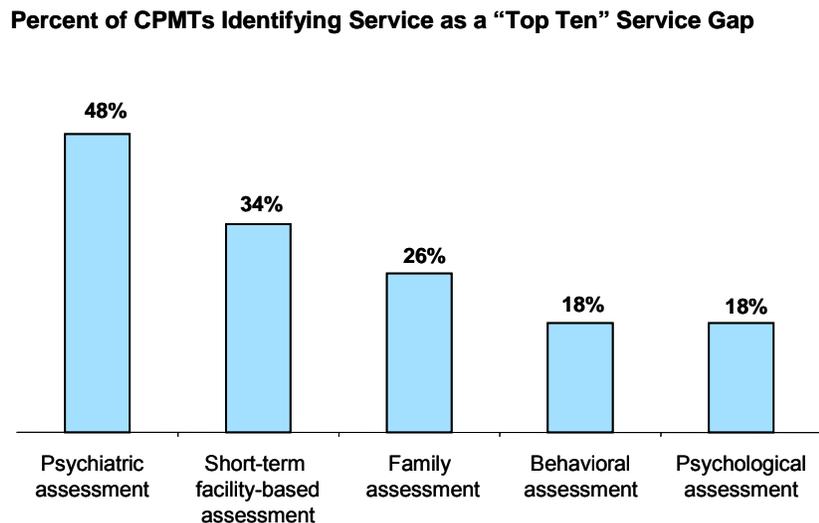
These services are all aimed at preserving family structure and allowing children to receive needed services without being removed from their homes, thus promoting the CSA's emphasis on family-focused service provision. Increased availability of family support services could mitigate against increasing foster care caseloads and out-of-home placement. If overwhelmed parents are given the appropriate tools to cope with the behavioral and emotional needs of their children, they may be less likely to surrender custody of their children to the State. According to a recent State Executive Council report, approximately one-quarter of children in foster care may be in the State's custody primarily to obtain needed treatment.

Lack of Assessment Services Hampers CSA Service Planning and Leads to Unnecessary Expenditures

The ability to accurately assess children's emotional and behavioral health needs is fundamental to designing appropriate service plans. However, CPMTs and other local program staff reported that they often do not have the tools or training to accurately assess children's needs. Further, because of a lack of community-based assessment services, relying on external professional resources for assessing children's needs is usually not feasible. One CPMT interviewed by JLARC staff stated that because so few localities have adequate assessment resources, children are sometimes "placed in the first residential facility that can take them" and from then on they are "diagnosed by how they fail." Three-quarters of CPMT representatives reported that assessment services are among the top ten service gaps for children in their communities and most frequently identified psychiatric assessment services as insufficiently available (Figure 31).

One CPMT interviewed by JLARC staff stated that because so few localities have adequate assessment resources, children are sometimes "placed in the first residential facility that can take them" and from then on they are "diagnosed by how they fail."

Figure 31: Services to Assess the Needs of Children and Families on an Outpatient Basis Are Insufficiently Available Statewide



Source: JLARC staff survey of CPMT chairpersons.

Local agency staff interviewed by JLARC staff reported that there are very few, if any, child psychiatrists available in their communities to perform comprehensive psychiatric assessments. In particular, most community mental health services staff serving on FAPTs and CPMTs reported that their community services boards (CSBs) do not have child psychiatrists on staff. While the multidisciplinary nature of CSA service planning could potentially serve as

a stop-gap measure for the lack of psychiatric assessment services, it does not substitute for the professional assessment required for children whose needs are beyond the clinical aptitude of local agency staff.

Insufficient local resources to conduct psychiatric assessments in the community not only affect the service plans developed by local CSA program staff, but also affect the ability of group homes to provide the array of services required by children in their care. In particular, because group homes generally contract with local clinicians to provide individual or group therapy services, they struggle to provide these services to their residents when there is a lack of child psychiatrists in the community. If these resource limitations keep a group home from meeting the therapeutic needs of children in their care, children may be placed in a residential treatment center instead, where child psychiatrists are employed as in-house staff. As described previously, residential treatment centers are one of the most restrictive and costly services available to CSA children.

One commonly reported approach taken by local programs to assessing children's needs in the absence of professional community-based resources is to place children in residential treatment facilities that offer diagnostic and assessment services where children are evaluated by facility staff over a period of 30 to 90 days. While facility-based psychiatric assessments may be appropriate for some children, this measure may be excessively restrictive and costly for children whose needs could be assessed on an outpatient basis, and it fails to include an assessment of family needs. However, even this resource is not widely available across the State. Because only a few providers offer diagnostic and assessment services, over one-third of localities indicated that this service is also lacking in their communities.

Localities Identified Gaps in Other Services That Could Allow Children to be Served in Their Homes and Communities

As shown in Figure 25, local CPMTs identified gaps in numerous other services that could be used to prevent the removal of children from their homes and communities. For example, more than half of CPMTs reported that outpatient substance abuse services are lacking in their communities.

According to local agency staff interviewed by JLARC staff, a lack of substance abuse services has several ramifications for the success of CSA participants. First, if children's substance abuse is not corrected, any investment in addressing other problems may be fruitless because substance abuse may be the root cause of those problems. Second, an inability to treat children's substance abuse

in the community could result in their being placed in facility-based inpatient treatment services. This removes them from their homes unnecessarily, which may be detrimental to their ability to improve. However, even inpatient substance abuse services may not be a viable alternative for many children because many local agency staff interviewed by JLARC staff reported that these services are also lacking statewide. Finally, a lack of outpatient substance abuse services also threatens family stability and a child's ability to return to the home if parents cannot access needed services for themselves.

CPMTs also identified a lack of outpatient behavioral health services, transportation services, substance abuse prevention programs, and vocational training opportunities as critical service gaps in their communities. All of these services contribute to a comprehensive continuum of care for CSA children and their families. When needed, an inability to access these services could hinder children's ability to overcome their difficulties or to maintain any progress they may have already achieved.

Potential Options for Alleviating Gaps in Community-Based Services

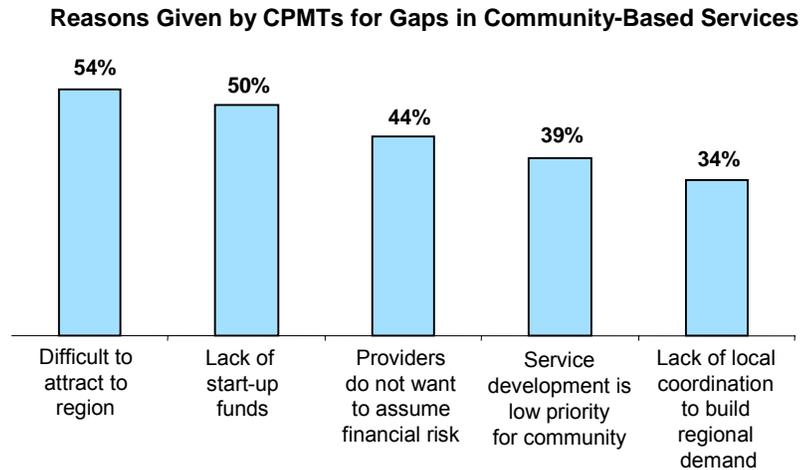
When asked about the nature of service gaps, CPMTs typically responded that services were either nonexistent in their communities or that services were present but did not have sufficient capacity to meet demand. Across all the services discussed in this section, the three most frequently reported obstacles are (1) difficulty in attracting providers to certain areas of the State, (2) lack of start-up funding to initiate service delivery, and (3) provider reluctance to assume the financial risk of developing a new service (Figure 32).

Based on the nature of these obstacles, it appears that efforts to address gaps in critical children's services could be bolstered by greater financial assistance from the State. Specifically, the State could

- expand the scope of competitive grants created in 2006 to further encourage the development of new services;
- allow localities to reinvest part of the costs avoided from using new services into the development of additional critical community-based services; and
- partner with private providers to assume a portion of the financial risk of developing capital-intensive services.

Additional Funding for Competitive Grants. Several local program staff suggested that local agencies could be successful in develop-

Figure 32: Primary Obstacles to Developing Needed Community-Based Services



Source: JLARC staff survey of CPMT chairpersons.

Regional Service Development

Using local funding, several CPMTs in the Southwest region of the State have jointly partnered with a local health care provider to develop an acute short-term mental health assessment center to ensure that children in need of emergency placements can remain close to their own homes and communities.

ing new services for CSA children if additional funding were available. Indeed, some local programs have successfully utilized local funding or federal grant monies to develop new services. However, many localities lack the staff capacity to apply for time-consuming and competitive federal grants, and most do not have the financial resources to fund the development of new services on their own.

In response, the 2006 General Assembly appropriated \$750,000 in Innovative Community Services grant funds to the Office of Comprehensive Services (OCS). These grants are to be awarded to localities on a competitive basis to provide start-up funds for new community services that will serve children who are in or at risk of being placed in residential care out of the community. Localities are expected to transition the newly developed services from grant funds to existing funding streams. In addition, grantees are expected to work with OCS to develop a methodology for calculating the residential care costs that are avoided. They will also recommend how State and local decision makers could reinvest a portion of these avoided costs into the development of more community services.

Although these grants hold promise for addressing critical service gaps, it is anticipated that they will be awarded to only four applicants depending on the amounts requested. In order to accelerate the development of community-based services on a broader scale, the State may wish to increase funding for these Innovative Community Services grants. To enhance their capacity to be competitive for these grant monies, local CSA programs should seek tech-

nical assistance and support from the OCS Technical Assistance Coordinator staff.

Recommendation (18). The Office of Comprehensive Services may wish to request additional funding for the Innovative Community Services grants to allow more local CSA programs to benefit from this State investment in new service development.

Virginia Systems of Care Grants

In fiscal years 2005 and 2006, the General Assembly appropriated a total of \$5 million in General Funds to the Department of Mental Health, Mental Retardation and Substance Abuse Services to expand the current system of care available for children and adolescents with behavioral health needs. These funds are granted to communities on a competitive basis.

State Could Allow Localities to Reinvest Savings into Further Development of Services. New services that are developed with the assistance of local funding or grants, such as systems of care grants, will not only improve the quality of care provided to CSA participants, but also result in lower per-child spending as more services are rendered in community-based settings. If a portion of this difference were reinvested in the development of still more community-based services, the benefits of bridging critical service gaps could be realized sooner and would not require additional State funding. Specifically, localities that have spent less State and local CSA money per child than in the previous year could be allowed to retain a portion of this difference to further address service gaps, and the remainder of the costs avoided would accrue to the State and localities. Spending differences should reflect changes in caseload because localities exercise limited control over the number of children they are required to serve.

This approach would also create an incentive for localities to adopt creative approaches to service development and to improve the cost-effectiveness of their programs because the costs avoided through their efforts would directly benefit the children they serve. In addition, this strategy would afford localities more flexibility because this funding source would not have to be used for specific children, which is a current limitation of CSA pool funding. Many local staff expressed frustration with this restriction and stated that it created an obstacle to addressing service gaps.

A similar approach was intended, but never implemented, when the CSA was first adopted. CSA stakeholders have indicated that a lack of start-up funds, which is now being addressed through the Innovative Community Services grants, was a key hurdle to achieving such savings.

Recommendation (19). The General Assembly may wish to consider allowing localities that spend less State and local CSA money per child from one year to the next to reinvest this difference in the development of new services to address critical service gaps in their communities. The Office of Comprehensive Services should work with localities and other relevant CSA stakeholders to develop a

methodology for quantifying this difference in expenditures in a uniform and equitable manner.

State Could Explore the Feasibility of Sharing Part of the Financial Risk With Providers in Developing New Services. According to some private-sector providers of children's services as well as local agency staff, more providers would be willing to enter the market if the State were to assume some of the financial risk of operating new services until the service becomes a viable business. For the more critical community-based service gaps – such as crisis intervention, psychiatric assessment services, and family support services – the State may wish to enter into a public/private partnership with the provider community and issue a request for proposals (RFP) for the development of these services in currently underserved areas of the State. As an incentive to recruit potential service providers, the State could offer to fund a portion of the capital needed to initiate and maintain service operation until the provider has a stable revenue structure.

LACK OF FOSTER FAMILIES IS A FREQUENTLY CITED SERVICE GAP

Regular Foster Care

These foster families provide basic maintenance, supervision, and parenting to children who are in the State's custody. These families must meet State standards and be approved by local departments of social services.

Therapeutic Foster Care (TFC)

TFC families receive additional payments for added daily supervision for children who have developmental, emotional/behavioral, physical or medical disorders. TFC parents must meet additional training requirements. Private child-placing agencies manage the majority of TFC services in Virginia and are responsible for TFC training and support.

Family-based foster care is a critical service gap identified by local Community Policy and Management Teams (CPMTs). When foster families are not available, children are often placed in more restrictive and costly service settings. CPMTs from all parts of the State who responded to JLARC's service needs assessment survey cited family-based foster care services as one of the top ten service gaps in their communities, either because there were no families available or because the demand for foster families exceeded their availability. Therapeutic foster care (TFC), which is intended for children with more severe needs, was the most-often cited type of service gap for family-based foster care.

In addition to the general lack of foster families in nearly all localities visited by JLARC staff, local programs also reportedly have difficulty finding foster families for children with particular characteristics or needs. In particular, local program staff indicated that foster families are frequently reluctant to care for adolescents, either because families prefer younger children or because they are unwilling to take on the more acute behavioral problems of older youth.

Lack of Regular Foster Care Families Results in Overly Intensive or Restrictive Services for Some Children

According to local program staff interviewed by JLARC staff, children may receive more intensive or restrictive services than they

need when foster families are not available. For example, staff of several local programs reported having to place children who could be cared for in a regular foster family home in a more intensive and costly TFC home because there are not enough regular foster care families in their communities. FAPT members in one central Virginia program estimated that half of all children in TFC placements could be served in less costly and less service-intensive regular foster family homes if more were available. Whereas regular foster families are compensated an average of \$411 per month, some private child placing agencies reimburse their TFC families from \$1,000 to \$1,600 per month.

Similarly, program staff reported having to place children in residential care when TFC families are not available or are not willing to care for those children. Insufficient TFC capacity is also reportedly a barrier to transitioning children back into the community from a residential setting. Compared to the \$1,000 to \$1,600 received by some TFC families, residential facilities charge an average of more than \$7,000 per month.

Enhanced Recruitment, Retention, and Compensation Could Enhance Availability of Regular Foster Care Families Statewide. Local program staff cited insufficient recruitment and retention efforts and inadequate compensation as the primary reasons for the insufficient supply of regular foster families. Recruitment efforts are currently limited or nonexistent within most local DSS offices, primarily due to resource constraints. According to DSS staff, the State does not provide any financial assistance to local DSS offices to support foster family recruitment so localities must rely upon local resources to finance these efforts.

Moreover, regular foster families reportedly receive limited training on caring for foster children and little ongoing support from their social workers. In fact, the State does not currently require foster families to receive any type of training. DSS has recently proposed new regulations that would mandate initial and ongoing training for foster parents, but these regulations have not yet been adopted. According to DSS staff, however, providing this mandated training will likely be difficult for localities to manage because funding to support these training efforts is scarce. Because of resource limitations, State DSS staff described training efforts as a "scramble" and "ad hoc" in many parts of the State.

The lack of training for foster care families can result in their underestimation of the emotional, mental, or behavioral problems of foster care children. Inadequate training and support not only generate reluctance to accept children with more acute needs into their homes, but also leads to premature placement disruptions and undermines retention when foster care families are confronted

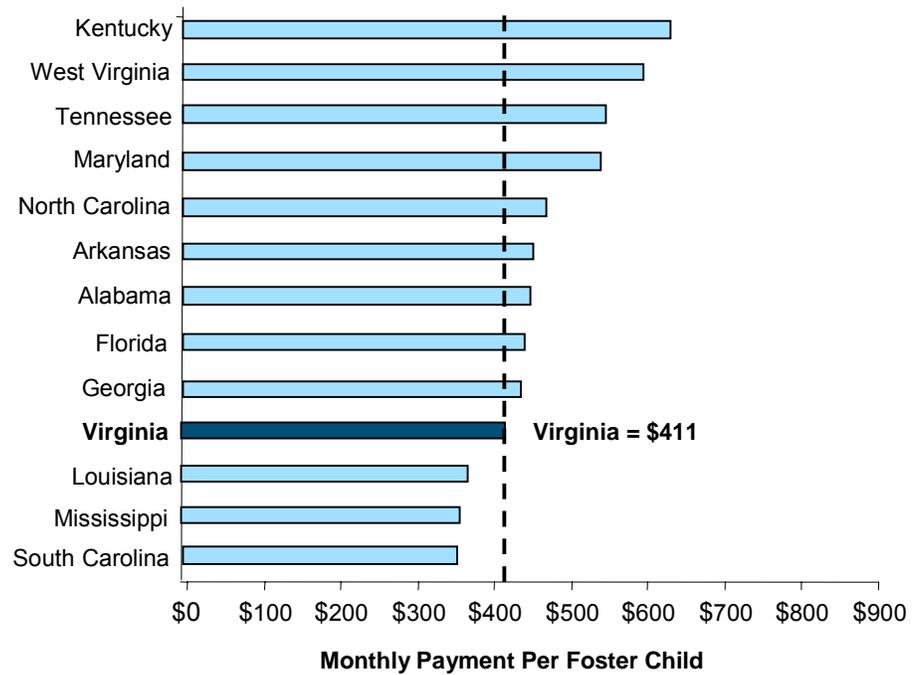
with unexpected behavior. Local CSA program staff reported that if additional training and ongoing support were provided, more families would be willing to foster a child and remain in the foster care program. For example, FAPT members of one Richmond-area program reported that three-quarters of the program's children placed in group homes could be served in a foster family home, but that foster families are not sufficiently trained or supported to meet the children's needs.

The low stipend paid to regular foster families also undermines recruitment and retention efforts. Some local program staff expressed frustration that although the State emphasizes the use of community-based and least restrictive services, this philosophy is undermined by the disparity in reimbursements for community-based versus residential foster care services. While group homes charge an average of \$3,000 per month solely for room and board, the average monthly stipend set by the State for regular foster families is \$411, or the equivalent of four days in a group home. This amount is supposed to cover expenses for room and board, clothing, personal care and recreation, and the child's monthly allowance and is one of the lowest among southern states, as illustrated by Figure 33. Moreover, local agency staff reported that because the reimbursement for TFC can be three times greater than the reimbursement for regular foster care, there is little incentive for individuals to become regular foster parents.

In Addition to Regular Foster Families, Localities Also Identified Gaps in the Availability of Therapeutic Foster Care Families. Therapeutic Foster Care (TFC) families are trained to handle the more acute needs of children with emotional, behavioral, developmental, or medical disorders. According to many local agency staff, there are not enough TFC families to meet demand. Nearly one-third of CPMTs identified a lack of TFC families among the top ten service gaps in their localities. As previously described, a lack of TFC families could result in children receiving services that are not the most appropriate for their needs and could lead to placement in an unnecessarily restrictive and costly care setting, such as a group home or a residential treatment facility.

One explanation for insufficient TFC capacity may be that TFC families are absorbing some of the unmet need for regular foster care. According to numerous local agency staff, because of a lack of regular foster families, many children are placed with a TFC family even though they do not require this level of care. This not only has a negative fiscal impact on the CSA program, but also may reduce the capacity of TFC families to serve children who actually require these more intensive services.

Figure 33: Virginia Foster Care Rates Are Lower Than Most Other Southern States



Source: Virginia Department of Social Services 2006 Annual Statistical Report.

In addition, local agency staff, as well as some private providers, observed that many TFC families become adoptive parents and therefore no longer accept children for foster care. According to one private provider who approves TFC families, those who become adoptive families tend to also be the most competent families. This provider stated that "our greatest success can be our biggest struggle" because while it results in children receiving permanent homes, it also reduces the provider's ability to meet the demand for TFC services.

Finally, some areas of the State may be especially underserved because there is insufficient demand to make TFC services a viable business. TFC families are typically recruited, trained, and reimbursed by private "child placing agencies." Without sufficient demand to generate adequate revenues, child placing agencies will not be able to operate a financially sound business and also will not have the resources to properly train and support TFC families. One representative from a large child placing agency explained that a good TFC program could not be developed for fewer than 15 children.

Steps Could Be Taken to Increase Number of Foster Families

One way to reduce the use of unnecessary residential care for CSA children would be to increase the supply and preparedness of foster families statewide. To achieve this goal, a stronger focus would have to be placed on the recruitment and retention of regular foster families, and compensation would need to be increased to reflect the demands of caring for a child. To this end, the State could use one or a combination of the following approaches, which are listed in order from the least to most comprehensive and difficult to implement:

- Issue a request for proposals to recruit and train foster families,
- Increase the stipend paid to regular foster care families,
- Establish a tiered stipend structure that increases based on the needs of individual children,
- Expand the public sector's capacity to recruit, train, and support foster families, or
- Outsource the support and case management of children in regular foster families to private child placing agencies.

The State Could Issue an RFP for the Recruitment and Training of Foster Families by Private Child Placing Agencies. One means to enhancing the capacity of regular foster care statewide would be to leverage existing private sector resources for the recruitment and training of regular foster families. As stated previously, the State does not provide local departments of social services with any funding specifically for the recruitment and training of foster families, and so local agencies must rely on uncertain local funding streams to manage these aspects of regular foster care. Because private child placing agencies specialize in the provision of foster care services, they possess greater resources for and expertise in foster family recruitment and training than most public sector agencies. In addition, private agencies also have a financial incentive to maximize the number of foster families available to them through their recruitment and training efforts. Because private agencies are already set up to conduct recruitment and training, this effort would be less time-consuming to implement than increasing the public sector's capacity to perform these functions.

Therefore, the State may wish to issue a request for proposals (RFP) to transfer the recruitment and training of regular foster families to the private sector using private child placing agencies. As part of this contract, the State could establish specific goals that are to be achieved, including the number and types of addi-

tional foster families to be recruited and the focus and frequency of training initiatives.

Monthly Stipend Paid to Regular Foster Families Could Be Increased. Currently, the average monthly stipend paid to regular foster families is \$411. Local CSA program staff across Virginia as well as several State agency staff reported that this amount is inadequate to cover the costs of caring for many, if not most, foster children. In fact, this amount is less than two-thirds of the federal government's estimate of the cost of raising a child. This in turn undermines State and local efforts to recruit new foster families and improve retention.

A range of options exist for increasing the monthly regular foster care stipend. These options are based on suggestions from State-level staff and an analysis of national data. Half of the cost of increasing foster care stipends would be covered by federal Title IV-E reimbursements for those children who are IV-E eligible. In 2005, 52 percent of children in the State's custody were eligible for IV-E funding. Virginia's monthly foster care stipend could be increased by

- 11 percent to \$456, which State DSS staff requested in the previous budget year. This would require approximately \$0.4 million in new federal, State, and local funding per month.
- 18 percent to \$485, which would make Virginia's reimbursement comparable to reimbursements granted in other states with similar levels of poverty. This would require approximately \$0.6 million in total new funding per month.
- 19 percent to \$489, which is the national average reimbursement for foster care families. This would require approximately \$0.6 million in total new funding per month.
- 49 percent to \$612, which is comparable to the reimbursement granted in Virginia's neighboring states. This would require approximately \$1.6 million in total new funding per month.
- 63 percent to \$670, which is equivalent to the federal government's estimate of the cost of raising a child in 2005. This would require approximately \$2.1 million in total new funding per month.

Currently, the State reimburses regular foster families different amounts depending upon the age of the child in their care. The amounts suggested above, however, reflect increases in the average amount actually paid to Virginia's regular foster families.

Tiering Stipend Could Be Paid to Regular Foster Families Based on Children's Needs. Because children can have vastly different needs, regular foster families could be compensated based on the extent of the care they must provide to meet the needs of individual children. This approach could remove financial barriers that currently preclude some families from becoming foster parents, particularly when children have intensive and costly needs. While the current average monthly stipend of \$411 could be sufficient to care for some children with very limited needs, this amount may be inadequate for other children. For example, the current stipend may not cover the cost of gasoline used to transport a child to frequent therapy sessions if the family lives in rural parts of the State. Furthermore, this option would compensate foster families more equitably based on the demands placed upon them.

Using the current average of \$411 as a minimum rate for children with the lowest level of need, the stipend could be increased in a tiered manner to reflect the demands of caring for children whose needs require additional efforts on the part of the foster family. For example, families caring for a child who requires constant supervision or must be transported to frequent medical appointments could receive a higher stipend to reflect the additional demands placed upon their time. In addition, families caring for children who are medically fragile and need extensive medical care could also receive higher compensation. For instance, one local staff member described the financial strain that was placed upon one regular foster family who currently cares for a child with severe cerebral palsy but receives no additional compensation to reflect this additional burden.

This tiered compensation approach is currently employed by child placing agencies to remunerate therapeutic foster families. In addition, in 2005 39 percent of local CSA programs provided supplemental payments to regular foster families who care for children with intensive needs, although some used this flexibility more frequently than others. For example, one locality pays families who provide specialized services and supervision an additional \$400 to \$3,000 per month, depending upon the child's needs.

This locality indicated that half of its foster families receive supplemental payments above the State minimum, and most of those are less than \$1,500 per month. Assuming a similar pattern, using tiered stipends could cost an average of \$1,066 per child per month, or \$655 more per child than under the current system. A portion of this amount would be paid by Title IV-E funds. In addition, this increase could be partially offset if some children are able to be served in foster families instead of residential settings. For example, Virginia would realize savings of nearly \$3,700 per

Virginia would realize savings of nearly \$3,700 per month for every child served in a regular foster family instead of a group home.

month for every child served by a regular foster family instead of in a group home.

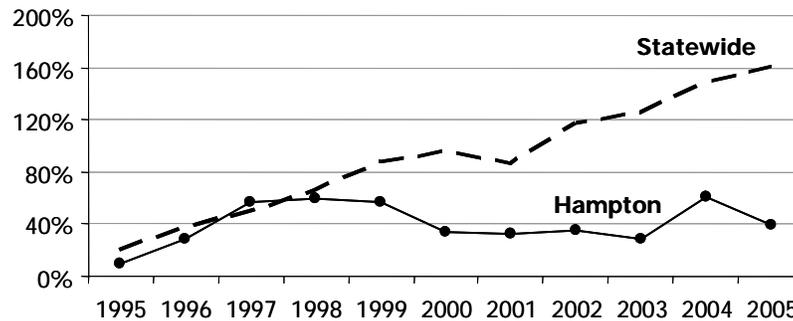
Expanding the Public Sector's Capacity to Recruit, Train, and Support Regular Foster Families. CSA stakeholders frequently indicated that in order to maximize the recruitment and retention of foster parents, families not only should be better compensated, but they should also receive greater support from local departments of social services. According to State DSS staff, many local departments lack both the human and financial resources to be able to respond to the needs of foster families in a timely or comprehensive fashion, and the primary role of social workers is to support the child rather than their family. However, child welfare stakeholders stressed that the key to attracting and retaining foster families is to provide them with a resource they can access immediately when problems arise.

To increase their supply of foster families, one local department of social services visited by JLARC staff has developed the capability to offer a level of support that exceeds what is available in most other localities. The city of Hampton has designated four staff to recruit, train, and support foster families. Moreover, a social worker is on call at all times to respond to any emergencies. Some foster families are trained by the department to act as coaches and mentors for new or struggling foster parents. As a result of their efforts, Hampton is able to serve a greater proportion of children in regular foster families than the rest of the State. On average, 38 percent of CSA participants in Hampton are served in regular foster families, compared to the statewide average of 22 percent.

While building recruitment and support capabilities in every local department across the State would require an upfront investment in additional staff, CSA spending could be reduced if local efforts to increase the supply of foster parents are successful. Hampton partly attributes its ability to control the rise in CSA spending to a focus on recruiting and supporting foster parents. As illustrated in Figure 34, CSA pool funding in Hampton has increased by only 39 percent since 1994, compared to a 161 percent increase in spending across the State. Moreover, Hampton's caseload has increased more than the State's total caseload over the same time period.

Outsourcing Case Management and Family Support to Private Providers. Finally, the State could consider creating a more seamless continuum of family-based foster care in which localities gradually outsource the recruitment, training, case management, and support functions for all types of family-based foster care to the private sector. As previously described, these functions are already being managed by private child placing agencies for TFC

Figure 34: Hampton's Cumulative Increase in CSA Pool Spending Far Below Statewide Average



Source: JLARC staff analysis of expenditures reported by Office of Comprehensive Services.

Privatized Foster Care in Kansas

Since outsourcing its foster care services in 1997, Kansas has realized the following benefits: finalized adoptions have increased 44 percent, foster homes are more often used than residential care, and caseloads are smaller than those formerly carried by public-sector staff. Prior to privatization, Kansas faced obstacles similar to Virginia, including service gaps, incentives for costly residential placements, and an absence of standards to measure service outcomes.

services, and child placing agencies have expressed an interest in extending their services to all types of family foster care. Compared to adding recruitment, training, and support responsibilities to staff in local departments of social services, this approach would

- leverage the existing recruitment, training, and support infrastructure and expertise already available in the private sector for TFC families;
- create a more centralized and efficient foster family recruitment, training, and support system than would be achieved by granting these responsibilities to 120 different local departments of social services that already struggle to perform their current responsibilities due to resource constraints;
- build the critical mass needed to attract more child placing agencies to less populated areas of the State by bringing together all children in need of foster families, whether regular or TFC;
- create one seamless foster care system rather than relying on disjointed and sometimes parallel efforts currently undertaken by both the public and private sectors; and
- alleviate the potential "welfare" stigma that may deter some potential foster families from working with local departments of social services.

Because of the complexity of implementing such a broad initiative, this effort could be implemented in three different phases. The first phase of this initiative would be to select specific localities to partner with private child placing agencies for the recruitment, training, and basic support services needed to attract and retain a sufficient number of regular foster care families. In this pilot phase, the State could establish specific goals that are to be

achieved, such as the number and types of additional regular foster families to be recruited and a desired retention rate. Local departments could retain their case management responsibilities for children.

In the second phase, these pilot localities would transfer case management functions to the private child placing agencies. The local department would instead oversee and monitor private sector performance in the provision of regular foster care services. If this pilot project is successful, the third phase of this effort would be to follow the same steps in introducing a public-private partnership for all foster care services statewide. This would result in the private sector assuming direct responsibility for all family-based foster care services in the State and granting oversight of this system to DSS and its local counterparts.

The potential cost savings of this effort are difficult to estimate because the amounts that private child placing agencies would charge for the training, recruitment, support, and case management of regular foster care have not been determined. Assuming that the cost of providing case management was the same when performed in the private as in the public sector, transferring this responsibility to child placing agencies should not result in incremental expenditures. Recruitment and training functions would result in additional cost because the State currently does not fund them at all. Based on input received from child placing agency representatives, training and recruitment are estimated to cost an average of \$450 per child per month. Finally, families would be compensated at a higher rate than under the current system. Assuming the tiered stipend structure previously described, the average incremental cost for higher compensation to families would be \$655 per child per month. The average cost per child in foster care would therefore increase by a total of \$1,105 per month, on average.

These additional expenditures would be offset, at least in part, by the "domino effect" this system would have as a result of expanding service capacity at the less restrictive end of the continuum of care. With greater regular foster care capacity, children receiving unnecessarily intensive services should be able to "step down" to a level of care that is more appropriate for their needs, which in turn would alleviate resource constraints along the entire spectrum of services for children. Moreover, additional benefits could be derived with respect to child welfare. For example, states that have outsourced foster care services have experienced increased rates of adoption and family reunification.

Recommendation (20). The Department of Social Services and the CSA's State Executive Council and State and Local Advisory Team, in consultation with representatives of Virginia's private child placing agencies, should conduct cost-benefit and feasibility analyses of five options to increase the number of regular foster families: (1) issuing a request for proposals to recruit and train foster families, (2) increasing the stipend paid to regular foster care families, (3) establishing a tiered stipend structure that increases based on the needs of individual children, (4) expanding the public sector's capacity to recruit, train, and support foster families, and (5) outsourcing the support and case management of children in regular foster families to private child placing agencies. The results of these analyses should be presented to the Secretary of Health and Human Resources, the House Committee on Health, Welfare, and Institutions, and the Senate Committee on Rehabilitation and Social Services no later than June 30, 2008.

LACK OF RESIDENTIAL SERVICES MAY UNDERMINE CHILD PROGRESS AND PRECLUDE RETURNS TO COMMUNITY

Residential Services

Group Homes
Residential setting characterized by a supervised homelike environment that serves groups of youths with behavioral/emotional difficulties and/or physical or mental disabilities.

Residential Treatment Facilities

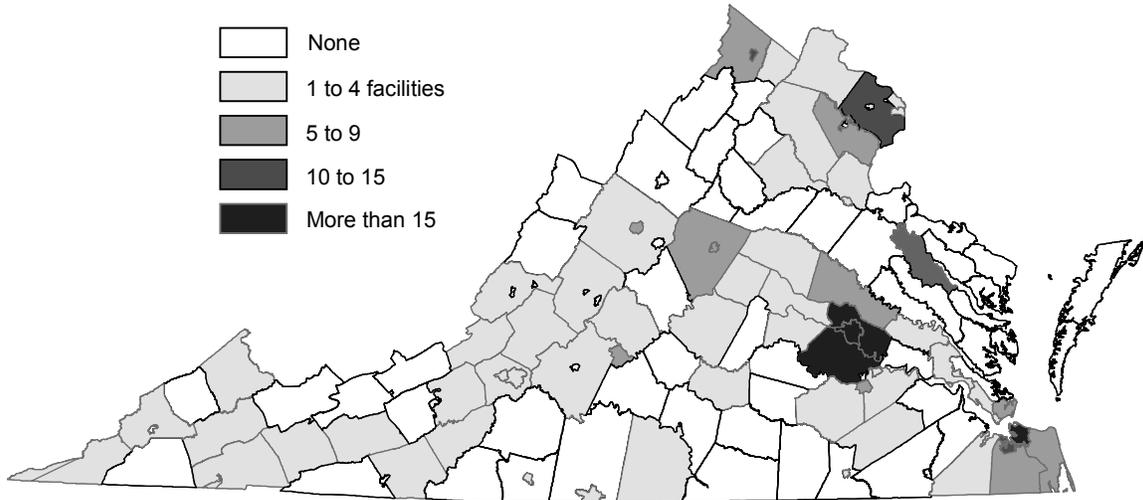
Residential care facilities where 24-hour intensive treatment rather than just supervision is offered. Intensive treatment services include medication management, special and regular education services, youth and family therapy, and other services.

Residential facilities are a critical component of the continuum of care because they provide services to children who cannot safely or effectively be served in the community. Residential care is especially appropriate for children with highly complex emotional and behavioral needs and who may present a threat to themselves or others. One-third of CPMTs that responded to the JLARC service gaps assessment indicated that group homes and residential treatment facilities were not sufficiently available in their communities. Although nearly 300 children's residential facilities are licensed to operate in Virginia, most are concentrated in only a few regions of the State. As a result, many children in need of residential care may be sent far from their homes and communities or receive services that are available in the community, which are often unduly intensive. Both of these scenarios can undermine their well-being and lead to unnecessary costs.

Most Localities Have Few, if Any, Residential Facilities

Approximately one-third of children's residential facilities are located in the central region of the State. Specifically, Henrico and Chesterfield counties and Richmond City host a combined total of 91 facilities of the nearly 300 statewide. As the map in Figure 35 illustrates, the majority have less than five children's facilities while few localities have more than 10. In fact, half of Virginia localities have no residential facilities at all, generating 2,609 cross-jurisdictional placements in 2006.

Figure 35: Children's Residential Facilities Are Concentrated in a Few Areas



Source: Office of Interdepartmental Regulations, March 2006.

Even when residential facilities exist in a community, they may not be accessible. CPMTs reported that local residential facilities can be full and unable to accommodate local demand. In addition, many facilities do not admit children who exhibit particular behaviors. In particular, local CSA programs have the greatest difficulty in securing placements for children who pose high liability risks (such as fire setters), or sex offenders or substance abusers.

Lack of Residential Services May Undermine Child Progress and Lead to Unnecessary Costs

When residential services are not available nearby, local CSA staff are reportedly faced with two options, both of which present therapeutic and fiscal disadvantages: (1) placing the child in a facility that best meets their needs but is far from the locality or (2) stepping the child up to a more restrictive setting than necessary but that is closer to the child's home. While some less restrictive facilities may be available nearby, they may not have the appropriate services to effectively address the child's needs.

Out-of-Community Placements Can Negatively Affect Child Well-Being and Increase Cost. When local alternatives are unavailable, children may be placed in residential facilities that are located outside of their communities or, in some cases, outside of Virginia. According to local CSA staff, unnecessary out-of-community placements hinder family/child interaction, which can be detrimental to the success of residential services and the ability to reunite children with their families. In either case, separating children from their families may undermine the effectiveness and

sustainability of residential services. In addition, placements in out-of-State facilities tend to be more costly to the State and localities. In 2005, 172 children were placed in residential facilities located in other states at a cost of \$12.7 million.

CSA stakeholders interviewed for this study consistently indicated that removing children from their families and communities could negatively affect their well-being and ability to surmount their behavioral and emotional problems. Local CSA staff and private providers alike indicated that family involvement is critical to ensuring long-term success, and that distance often precludes families from regularly engaging in their child's service plan or participating in family counseling. It is important to note that in some cases, children may benefit from being served away from their community if their environment contributed to their problems. For example, one local FAPT explained that a youth who had been involved in drug-related activities had purposely been placed in a distant facility in order to sever inappropriate relationships.

Out-of-community placements may also result in protracted residential stays because designing an effective discharge plan can be much more difficult for these children, according to local staff. For example, children cannot work with providers from their locality due to distance, which hampers their ability to gradually transition to a community-based setting.

Lack of Group Homes May Also Result in Unnecessarily Restrictive and Lengthy Placements. When a community's continuum of care does not include group homes, children who could benefit the most from group home care may be placed in more restrictive residential treatment facilities. Serving children in unduly restrictive environments may not appropriately address their needs and may also compound the difficulty of transitioning them back to the community from a highly institutional environment. Due to the frequent lack of community-based services discussed earlier, it can be impossible to avoid overly restrictive placements by wrapping necessary services around the child in their home, school, or community.

Local CSA staff explained that group homes are an effective means of gradually transitioning children from the high level of structure and supervision provided in residential treatment facilities to the greater independence afforded in family-based settings. Without this interim service, youths may not sustain the progress achieved in the residential treatment program. As a result, investing in these costly treatment services may not yield long-term benefits in the absence of appropriate subsequent group home care. In addition, foster families may be reluctant to open their home to a child who was most recently in a high-intensity facility. This perception may further add to the difficulty of securing foster families for

older youths, as well as delay the discharge of children back to the community.

LACK OF LOCAL SERVICES RESULTS IN PLACEMENTS OUTSIDE OF COMMUNITY

According to CSA stakeholders, the need for out-of-community placements arises primarily from the lack of local services. When needed community-based or residential services are not available in a child's community, they may be sent to other parts of the State where these services are available. If the facilities that offer needed services are not within the community, they will be provided in a costly residential setting elsewhere in Virginia.

While securing appropriate services is critical to helping children overcome problems, receiving these services outside of the community can lead to negative consequences for the child and fiscal ramifications for the locality where the child is placed. Bridging local service gaps could significantly reduce the need for cross-jurisdictional placements. However, these placements will not be completely eliminated because developing a full continuum of care in every locality would be redundant and inefficient.

Most Children Are Placed in a Few Localities

During the first six months of FY 2006, more than 2,100 children received residential care in Virginia but outside of their locality. These placements were concentrated in a few localities (Figure 36). In fact, half of these youths were placed in just eight localities. According to CSA staff and private providers, residential facilities tend to open in areas that exhibit the following characteristics:

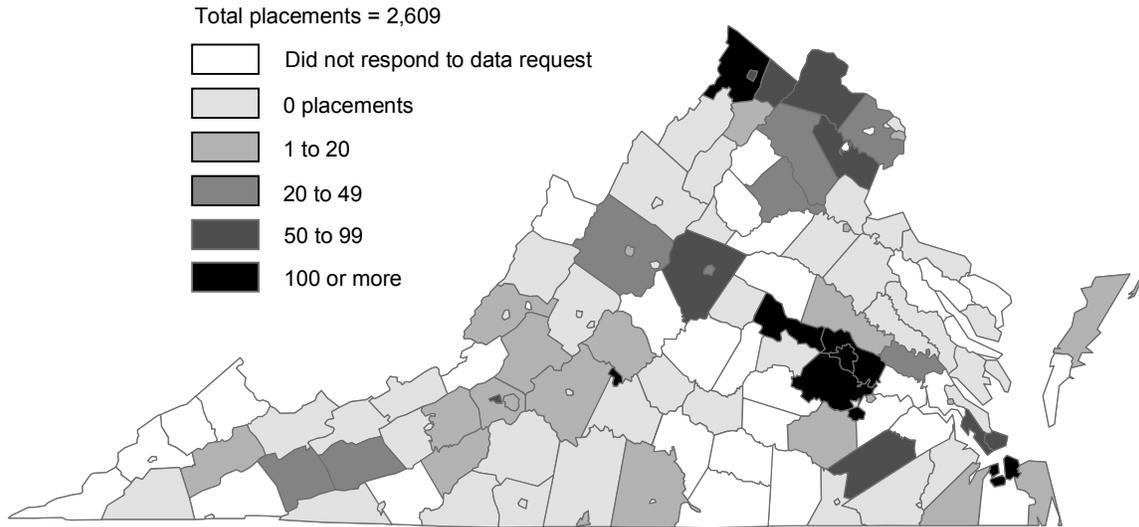
- access to community-based services, especially in the case of group homes that frequently utilize local providers to deliver clinical services,
- ample supply of qualified staff, and
- low cost of living.

Facilities may continue to open in areas that appear to be saturated because they can also serve children who are sent from other parts of the State. One means to avoid further market saturation may be to require new applicants to learn more about the viability of their facility by developing a business plan. However, additional controls could be put in place to ensure that new programs fill a market need before receiving a license to operate in the State. This issue was discussed in Chapter 2. Figure 37 illustrates the locali-

Cross-Jurisdictional Placements Data

Local CSA coordinators were asked to report the number of children who were placed in residential facilities outside of the jurisdiction between July 1, 2005, and December 31, 2005. Seventy-seven percent of localities responded to this request, representing 91 percent of all children who received residential care during that period.

Figure 36: Few Localities Receive Cross-Jurisdictional Placements



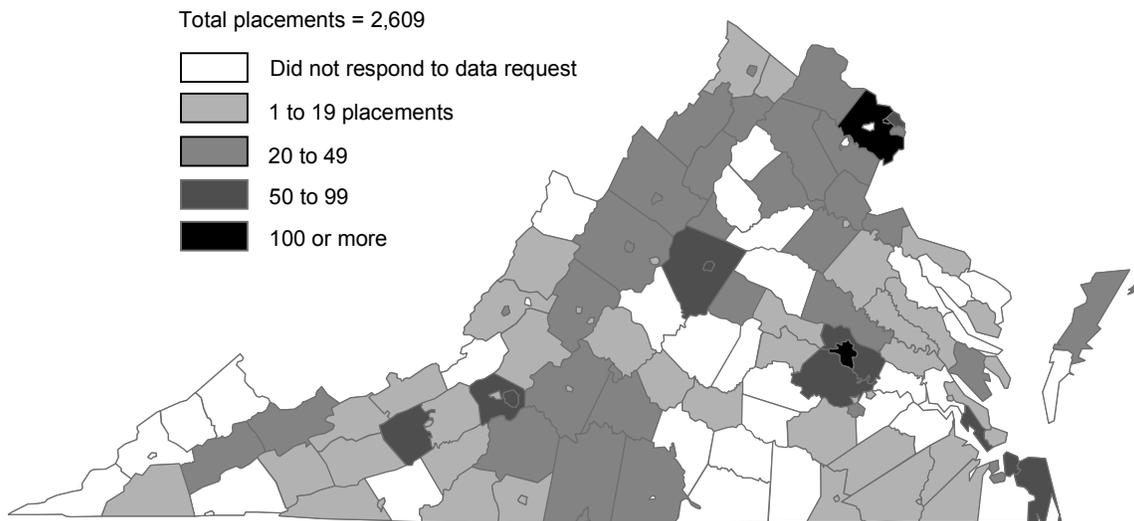
Source: JLARC staff analysis of cross-jurisdictional placements reported by local CSA coordinators.

ties that place the largest number of children in facilities located outside of their jurisdiction

Cross-Jurisdictional Placements Negatively Impact Local Budgets as well as Children’s Well-Being

According to CSA stakeholders and local representatives, cross-jurisdictional placements may not only have negative effects on children’s well-being but also on localities’ budgets. Localities that host a large number of residential facilities may experience strained public infrastructures and bear costs not generally reimbursed through the CSA program. Children who receive residential care may exhibit behavioral problems that impact the greater community, have special education or behavioral difficulties that impact the local school system, or have serious medical needs. As a result, they are likely to use local resources such as law enforcement or emergency medical services more so than other children. For example, a study conducted by a locality that hosts a large number of children’s facilities found that residential facilities placed more than twice as many calls for police service than other residents. In addition, because many of the youths residing in group homes are educated in public schools, their educational costs are partially paid by the host locality. Finally, local governments may have to manage citizen complaints if children’s behavior affects the wider community.

Figure 37: Most Localities Place Children Outside of Jurisdiction, But Few Send Large Numbers



Source: JLARC staff analysis of cross-jurisdictional placements reported by local CSA coordinators.

Representatives from localities that receive a large number of children from other parts of the State explained that many of these problems are isolated to a subset of providers who are not committed to providing quality services. For example, they cited a lack of adequate staff supervision of residents as a frequent reason for police calls. These officials suggested that improving the qualifications and availability of staff in residential facilities could minimize such incidents, thereby reducing some of the burden placed on local agencies that must respond to them. The issues of qualifications and staff supervision were discussed in Chapter 2.

Addressing Local Service Gaps Would Eliminate Need for Many, but Not All, Cross-Jurisdictional Placements

The majority (55 percent) of CSA coordinators who responded to a JLARC staff survey indicated that when appropriate services are not available locally, children are placed outside of their community “frequently” or “most of the time.” Bridging local service gaps could therefore alleviate much of the burden placed on children and localities as a result of out-of-community placements. However, offering certain services in every community would create a redundant, inefficient, and ineffective service delivery system. For example, according to CSA stakeholders and private providers, some residential facilities offer highly specialized services for children who exhibit severe and rare behavioral problems such as fire-setting or self-mutilation, or who are sex offenders. A relatively small number of children exhibit these issues, and creating ser-

vices to serve them in every community would be inefficient. Moreover, it is unlikely that sufficient demand exists in each locality for every service along the entire continuum of care.

Rates Charged by Residential Facilities Not Consistently Regulated by Market Forces

In Summary

Rates charged by residential facilities do not appear to always be efficiently controlled by market forces due to a lack of information upon which to base service decisions. Some residential facilities charge rates that do not appear to be commensurate with the scope or quality of services provided. In particular, the rates charged by for-profit group homes are not as closely linked to program characteristics, compared to other types of facilities. In addition, certain facilities generate profit margins that appear excessive compared to most industries' rates of return. However, it is unclear to what extent their financial performance is driven by efforts to boost profits rather than the result of volatility. Although these issues are of concern, they appear to be contained among a subset of providers who receive a limited amount of State and local funding. Inadequate access to information appears to have facilitated these higher rates; this issue could be addressed by improving the accuracy and content of the State's database of children's service providers. Moreover, access to better information may also help ensure that children receive the most appropriate services to address their needs.

The mandate directing this study places great emphasis on understanding whether the high cost of residential services is justifiable given the scope and quality of services received. In addition, a key question posed by State and local CSA staff is whether deregulation has allowed for excessive profitability. Children's residential facilities were subject to a rate setting mechanism until 1993. With the passage of the Comprehensive Services Act of 1992, rates were deregulated in order to facilitate the development of more creative and cost-effective services through greater competition. A lack of data has prevented State and local stakeholders from definitely concluding whether free market forces are successfully managing residential rates. As a result, mixed opinions exist about the utility of restoring a rate setting system.

RATES OF FOR-PROFIT GROUP HOMES DO NOT APPEAR STRONGLY ASSOCIATED WITH INTENSITY OF SERVICES

Facilities that charge higher rates do not appear to consistently provide more intensive, comprehensive, or higher-quality services, and this is particularly true among for-profit group homes. Furthermore, some for-profit children's residential facilities appear to be generating substantial after-tax profit margins, based on a JLARC staff analysis of providers' financial statements. While Virginia may not be maximizing its return on the large investment made in residential care for CSA participants, a relatively small

Research Methods

JLARC staff analyzed the 2004 and 2005 financial information supplied by 126 providers of children's residential services in Virginia. These providers account for 83 percent of all licensed providers of children's residential services who receive CSA funding in Virginia. Financial information was self-reported by providers and has not been audited by a certified accountant.

amount of public funding is spent in facilities that appear to be less cost-effective. It is important to note that financial information was self-reported by providers and was not audited by a certified public accountant. However, the information was reviewed by JLARC staff for reasonableness.

For-Profit Group Homes Tend to Charge Higher Rates Without Providing More Intensive Services

Residential facilities structure their programs differently in order to offer services that meet the varied individual needs of the populations they serve. Most facilities can generally be categorized as either group homes or residential treatment facilities depending on their intensity of services and size, yet many differences exist between these two categories. To administer its specific program, each facility must decide on the proper amount of resident supervision, minimum staff qualifications, and the scope of services available in-house, among many other factors. Facilities that choose to provide closer resident supervision, employ more qualified staff, or offer more extensive services would be expected to charge higher rates in order to finance these added program elements.

An analysis of the variation in the rates charged by residential facilities suggests that programmatic differences do not entirely explain rate differences. While program characteristics appear to largely account for differences in the rates of residential treatment facilities, they do not explain as much of the variation in group home rates. In particular, the rates charged by for-profit group homes are the least closely tied to the scope of services offered in these facilities.

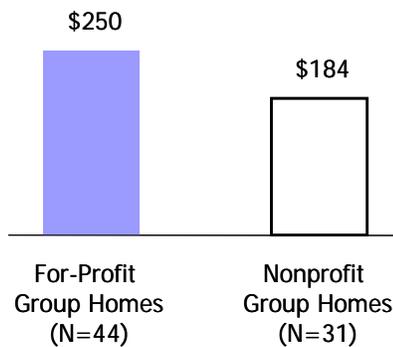
Unlike Other Facilities, For-Profit Group Homes that Charge Higher Rates May Not Consistently Offer More Services. Residential treatment facilities that charge higher rates appear to usually offer more intensive and comprehensive services by employing staff who are more highly qualified, having higher staffing ratios, or holding a certification above the State's minimum requirements. This conclusion is based on statistical analyses that are discussed further in an online appendix. In contrast, there is a weaker association between the rates charged by group homes and the scope of services they offer. This weaker association indicates that group homes that charge higher rates do not consistently offer more services.

In addition, there is a strong association between whether group homes are for-profit or nonprofit and the rates they charge. This finding suggests that for-profit group homes tend to charge more than nonprofit group homes facilities for providing the same level

For-profit group homes tend to charge more than nonprofit group homes facilities for providing the same level of services.

of services (Figure 38). For-profit facilities may charge more in order to meet investor expectations, pay taxes, and because, unlike nonprofit organizations, they rarely receive private donations that can be used to supplement public and private resident fees. However, the State and local governments may not be maximizing their investment in residential care if a significant portion of their funding is generating profit for private providers.

Figure 38: For-Profit Group Homes Charge More per Day than Nonprofit Group Homes, on Average (2006)



Source: JLARC staff analysis of provider survey results.

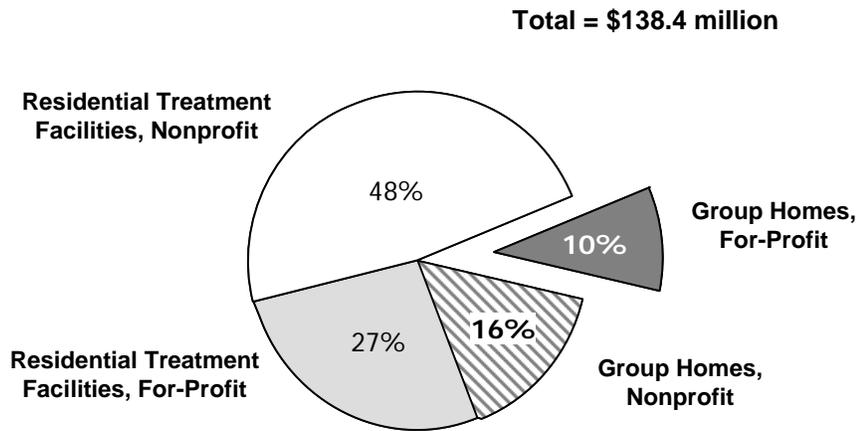
These quantitative results are consistent with the concerns expressed by nearly all CSA stakeholders and licensing staff interviewed for this study. While many described several for-profit group homes that offer high-quality programs, they also expressed concern that some homes are in operation primarily for financial gain and that their interest in serving children is secondary. In fact, licensing staff described local seminars on “becoming a millionaire by opening a group home,” and reported often fielding calls from potential applicants interested in converting a house they inherited into an income-producing residential facility. In addition, many local case managers described facilities that provide only custodial care, yet charge as much as programs that offer more comprehensive services.

Although most local CSA staff generally attempt to place children in facilities they believe to be cost-effective, they reported sometimes having to default to other programs for two primary reasons. First, local staff explained that comprehensive information is not always available to determine the scope and quality of programs offered by individual facilities and, consequently, whether their rates are appropriate. Second, in some cases, staff may have few other options than to pay a premium to secure a placement because the most cost-effective providers are unable to admit a particular child. For example, some children may need an immediate placement, fail to meet the admission criteria of cost-effective pro-

viders, or have previously been removed from those providers' programs.

For-Profit Group Homes Receive Ten Percent of Public Funds Spent on Residential Care. While the use of facilities that may not be consistently cost-effective should be of concern to the State and local governments, a relatively small proportion of CSA funds is spent on children served in facilities for which rates do not consistently appear justifiable. Only ten percent of all public revenues spent in facilities that responded to the JLARC staff survey were received by for-profit group homes (Figure 39). This suggests that the majority of residential expenditures are incurred in facilities that appear to charge fees that are commensurate with the scope of services they provide.

Figure 39: Proportion of Public Funding Received, By Facility Type



Note: Figure includes public funding received in 2005 by residential providers who participated in the JLARC staff survey.

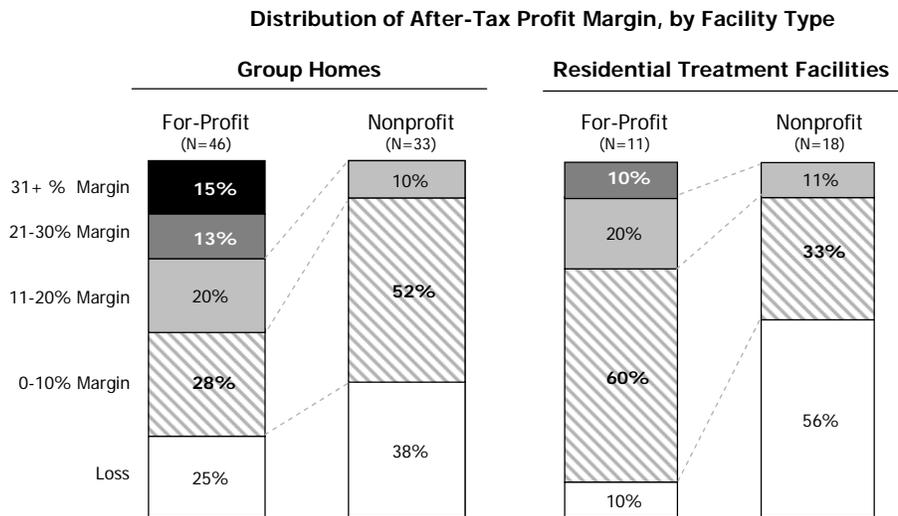
Source: JLARC staff analysis of residential provider survey data.

Many For-Profit Group Homes Earn Seemingly Excessive Profit Margins, but High Profits Are Not Always Sustained

Some children's residential facilities, in particular for-profit group homes, earn significantly higher profit margins than most U.S. industries. In fact, 15 percent of for-profit group homes realized after-tax profits in excess of 30 percent in 2005. However, it is unclear whether high levels of profitability are consistently the result of concerted efforts to boost profit margins or occur due to volatility in market conditions and financial assumptions. Facilities that generate high profit margins appear to receive a relatively small proportion of all public funding spent on residential care.

Some For-Profit Facilities Earn Returns in Excess of 20 Percent. Although for-profit businesses can rightfully be expected to generate positive profit margins, it appears that some for-profit children's residential facilities, in particular group homes, are excessively profitable. Based on an analysis of their 2005 financial statements, nearly 30 percent of for-profit group homes generated after-tax profit margins in excess of 20 percent, and 15 percent of those homes earned more than 30 percent net returns on revenues (Figure 40). In contrast, none of the nonprofit facilities had profit margins above 20 percent, and all excess revenues were reinvested into the facility in accordance with tax regulations.

Figure 40: Some For-Profit Group Homes Earn Profits Over 20%

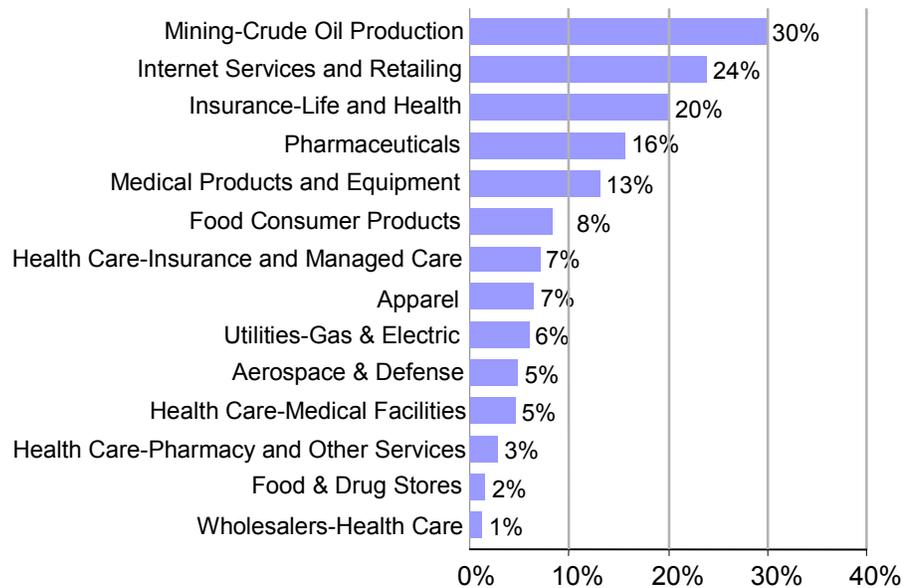


Source: JLARC staff analysis of provider survey results.

Compared to the average profit margins realized by major U.S. industries, it appears that some residential facilities are enjoying generous returns. Industries that provide health-related services earn less than seven percent returns on revenues, on average, with the exception of pharmaceutical and medical equipment companies, which generate profits of 16 and 13 percent, respectively. In fact, only Internet service providers and the oil industry earn more than 20 percent returns (Figure 41).

Some Facilities May Not Intentionally Pursue Excessive Profit Margins. Facilities do not appear to consistently realize similar rates of return over time, suggesting that some providers may not be deliberately pursuing high levels of profitability. Rather, some facilities may experience favorable changes in market conditions or could lack the experience to accurately project spending and occupancy.

Figure 41: Average Profit Margins of Major U.S. Industries



Source: *Fortune* magazine, "Top 50 Most Profitable Industries," April 17, 2006.

Many of the facilities that realized high returns in 2005 had lower profit margins or losses in the previous year. For example, 43 percent of facilities that had returns in excess of 30 percent in 2005 had incurred a loss in 2004. The difference in profitability from one year to the next suggests that some changes occurred to affect either revenues, spending, or facilities' targeted rates of return.

Facilities' profits are the product of the rates they charge, the number of children they serve, and the amount they spend to operate their programs. Based on interviews with residential providers, facilities establish their rates at a level which, multiplied by the number of children they expect to serve, enables them to fully meet their expenses and, in the case of for-profit facilities, achieve a targeted rate of return. If actual spending is below the budgeted amount or more residents are admitted than was expected, then profits will exceed expectations. Actual spending may be lower than budget if facilities have unexpected staff vacancies, for example. In addition, occupancy may be higher than projected if more children need residential care or more referrals are made to a particular facility than expected.

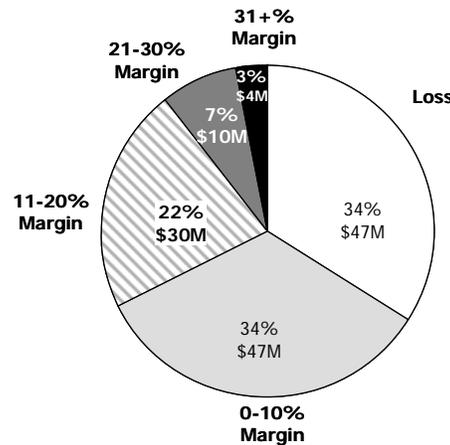
Providers may achieve better financial results than expected because they lack the history needed to develop accurate assumptions. Most facilities that earned high returns in 2005 were new programs. Nearly 70 percent of facilities that earned more than 20

percent returns had been in operation for less than two years. Without a long financial history, facilities may be unable to accurately create expense budgets and forecast occupancy rates. As a result, their rates may yield excess profits because they are too high to simply cover expenses and targeted profit margins. Alternatively, actual occupancy may exceed projections and result in higher than expected revenues that will increase profit margins.

Limited Share of Public Revenues Spent in Highly Profitable Facilities. The majority of public funding spent on residential care is received by facilities that earned less than ten percent returns or incurred a loss in 2005. Facilities that realized higher returns received a smaller proportion of public money (Figure 42). In fact, the combined amount of profits realized by facilities whose returns exceed 20 percent was \$4.4 million, or 3.2 percent of total public revenues.

Figure 42: Two-Thirds of Public Funding Spent in Facilities Earning Less than 10 Percent Returns in 2005

Share of Public Funding Received, by Profitability Level



Source: JLARC staff analysis of residential provider survey results.

LACK OF INFORMATION MAY DISTORT RATES AND LEAD TO INAPPROPRIATE PLACEMENTS

Insufficient information appears to be a primary factor that enables some residential providers to charge higher rates than may be justified and in some instances realize high profit margins. The absence of accurate and accessible information undermines market efficiency by failing to ensure the delivery of high-quality and fairly priced services. In order for a market-driven service delivery system to ensure that only high-quality and fairly priced services are purchased, local CSA decision makers need accurate and com-

prehensive information about the quality, nature, and cost of available children's services. Although the State and several stakeholder groups maintain some information for residential services, most of that information is not consistently or efficiently collected and shared with CSA decision makers. Without this information, CSA programs may pay too much for a service because they are unable to determine whether service rates are reasonable relative to the scope or quality of what they are purchasing. Furthermore, CSA decision-makers may inadvertently connect children with inappropriate or low-quality services.

Lack of Information Undermines Market Efficiency

In the absence of complete and accurate information, consumers cannot make rational decisions about which services are most cost-effective, and prices no longer reflect the value derived from a service. In the context of children's residential services, not only is Virginia's return on its financial investment undermined, but the well-being of children is endangered. When local staff lack the information to determine whether a residential facility meets a child's therapeutic needs, has successful outcomes, and is safe, inadequate service decisions may be made.

By increasing access to information about each provider's services, quality, and effectiveness, local CSA staff can create better service plans. Furthermore, they can use this information to strengthen their ability to negotiate rates, whereas the balance of negotiating power is currently weighted toward providers. Providers and local CSA staff alike report that facilities are only willing to reduce rates if the referral source places a substantial number of children with them or is willing to purchase a certain number of beds each year, and that provider performance rarely enters into negotiations.

Centralized and Accurate Information About Nature and Cost of Residential Services Is Lacking

Local CSA program staff have no reliable source of information to compare the costs of similar children's services against individual program characteristics, effectiveness, and compliance record.

Local CSA program staff have no reliable source of information to compare the costs of similar children's services against individual program characteristics, effectiveness, and compliance record. The State-maintained database on the services offered and rates charged by Virginia's residential facilities is reportedly inaccurate and unreliable; information collected by State licensing agencies on facilities' compliance with State health and safety regulations is not easily accessed by local CSA staff; and the State collects no information on the effectiveness of individual residential facilities in shaping positive child outcomes.

Basic Program Characteristics Not Consistently Available. The Office of Comprehensive Services (OCS) maintains a web-based catalogue of information about children's residential providers called the Service Fee Directory (SFD). The SFD includes information on the services that residential facilities offer and the rates that they charge. This database was originally designed as a centralized resource for providers to enable consumers to compare the cost of similar CSA services and was expected to facilitate the free-market regulation of children's service rates. However, the information contained in the SFD is often inaccurate, dated, and not sufficiently user-friendly to fulfill its intended purpose.

The dubious quality of the information contained in the SFD has been acknowledged by OCS staff, one of whom described the directory as a "buyer beware" resource.

Local CSA program staff in all 17 local programs visited by JLARC staff unanimously agreed that the SFD is not useful. In fact, many program staff stated that they only use the directory to obtain provider contact information. The dubious quality of the information contained in the SFD has been acknowledged by OCS staff, one of whom described the directory as a "buyer beware" resource. The following list summarizes the primary weaknesses of the SFD, as reported by local CSA program staff:

- Information is self-reported and updated by service providers and accuracy is not verified by a third party.
- Information is unreliable and incomplete because providers do not consistently populate all of the information categories in the SFD.
- Information is often out-of-date. For example, the SFD contains information on facilities that are no longer operating.
- The design of the SFD is not user-friendly, in particular because consumers cannot search for facilities by specific localities or regions and are unable to search by multiple service criteria, such as services for children with both "autism" and "substance abuse" and who are "ages 13 and older."

Because the SFD is the only centralized information resource for local CSA decision-makers, program staff tend to rely instead on information acquired through their correspondence with other local CSA programs and their past experiences with providers. However, this information is not always accurate and may not be available quickly enough to facilitate emergency placements. Moreover, few localities are able to dedicate limited staff resources to cataloguing detailed information about provider rates and services.

Effectiveness of Children's Residential Programs Not Measured or Communicated. In addition to being unable to compare the cost of similar types of services, local CSA program staff do not have information to determine whether provider rates are consistent with

Local program staff indicated that they have recommended the use of lower quality providers because they did not have enough information to fully assess the quality of their services.

the effectiveness of their services. In an efficient market, facilities that provide more successful outcomes could command higher rates, but the current system does not facilitate this type of differentiation. Although the State has engaged in extensive discourse about measuring and reporting the effectiveness of children's services, these efforts are fairly recent. In the absence of statewide information about which programs appear to work and for which types of children, local CSA staff may not be consistently using providers who are best suited to address individual children's needs and are, therefore, most cost-effective. In fact, over one-third of respondents to the JLARC survey of local CSA programs indicated that they have recommended the use of providers whom they subsequently found to be lower-quality because program staff did not have enough information to fully assess the quality of their services.

Facilities' Health and Safety Records Not Readily Available to Local Staff. Compliance records should be another factor to affect the rates that facilities can charge and the number of children who are referred to their programs until recently. Records of residential facilities' compliance with licensing standards were not proactively shared by licensing agencies with local CSA programs until recently. As a result of requirements set forth in House Bill 577 (2006), the Office of Interdepartmental Regulation (OIR) began notifying OCS of changes in the licensure status of residential facilities resulting from violations of health and safety or human rights standards in July 2006. OCS distributes this information to CPMT Chairs and CSA coordinators.

While State licensing specialists indicated that consumers can request other information from regulatory agencies on the violations committed by residential providers, many local CSA staff are reportedly unaware that they can obtain this information upon request. In addition, even when this information is made available, it is not always conveyed in a way that is useful to CSA staff because they may lack the expertise and context to determine the severity of violations. State licensing specialists have expressed reluctance to provide context or interpretation because of concerns over legal exposure if such information-sharing caused providers to lose business.

A lack of knowledge about facilities' ability to preserve the health and safety of their residents could compromise children's well-being. Furthermore, facilities with questionable compliance records may continue to receive referrals if local CSA staff are not aware of compliance concerns. As a result, these facilities may not have much incentive to improve if they experience limited financial consequences.

The majority of respondents to the JLARC staff survey of local CSA programs indicated that better information about regulatory violations would improve the administration of their local programs. Staff at DSS and DMHMRSAS indicated that they are in the process of making information about violations available through their agency websites. However, those websites will not contain some of the information that specialists suggested would be most useful to local CSA decision-makers, such as the severity and nature of violations.

Access to Centralized Information Could Improve Local Placement and Spending Decisions

Because responsibility for obtaining information about residential programs rests primarily with local CSA programs, most are unable to make the most informed service purchasing decisions. Improving consumer access to more comprehensive and accurate information on the cost, quality, and effectiveness of children's residential programs could enhance market efficiency and better control rates. In addition, better information would also enable local CSA decision-makers to connect clients with the most appropriate, safe, and effective services available.

Basic Information Included in Service Fee Directory Should Be Enhanced and Monitored to Ensure Accuracy. To reduce duplication of effort and ensure that all local programs have equal and timely access to basic information on the availability and quality of children's services, the State should build upon the information provided in the SFD and take steps to ensure that this information is accurate and current. Specifically, OCS should consider revising the SFD to include the following elements:

- accurate provider contact information,
- provider capacity and average occupancy rate,
- a profile of children served,
- the most common three to five services offered by each provider and key components of their program,
- typical duration of a provider's treatment programs,
- rates charged for each service provided, unbundled by service component, and
- returns on revenue for past two fiscal years.

In addition, the database should be searchable by child characteristics and region. Local CSA staff should be able to identify providers who serve children with specific characteristics in order to most effectively link children to suitable services. In addition, the

ability to search for providers who are located within a certain distance from the referring locality would help staff identify services available within their communities.

OCS and licensing agencies should also work with local CSA program staff and the private provider community to identify additional or alternative useful revisions that could be made to the SFD to improve service planning and delivery to CSA children. To promote greater accuracy of the information in the directory, each local CSA program's service contract should require providers to submit certain information to the directory and update it at least on a quarterly basis. In addition, OCS should be responsible for validating the accuracy of the data entered into the directory by individual providers.

Quality Rating Systems in Other States

In 2006, at least 13 states had established quality rating systems for child-service programs. For example, Tennessee gives child care providers a report card that reflects performance in several areas including staff qualifications, regulatory compliance, and family involvement. North Carolina gives one to five "stars" to child care programs based on their quality in the areas of program standards, staff education, and compliance history.

Stakeholders Could Design a Rating System to Organize and Communicate Information about Provider Quality. OCS should also take steps to include information regarding provider quality and effectiveness in the SFD. Centralizing this information would allow local CSA program staff to more efficiently access the information they need for purchasing the most appropriate and fairly priced residential services. One user-friendly approach would be to create a comprehensive quality rating system that gives an overall assessment of provider performance. Ideally, this rating system would incorporate information from many different stakeholder groups, including residential providers, State licensing agencies, OCS, and local program staff.

Specifically, facilities would be rated based on the factors that CSA stakeholders identify as important for ensuring high quality services. A consortium of local CSA program staff, residential providers, OCS staff, and regulatory agency staff should determine which factors are most useful, measurable, obtainable, and fair in assessing provider quality. The effectiveness of services could be assessed by collecting child outcome measures and feedback from customer satisfaction surveys.

Outcome measures could be reported by residential providers and calculated based on information contained in the CSA child-level dataset. Details on this recommendation are included in Chapter 3. Customer satisfaction surveys could offer more immediate and up-to-date information about provider performance. The CSA State and Local Advisory Team (SLAT) has been developing a service evaluation tool by soliciting the input of numerous local stakeholders. The State Executive Council, which is the supervisory council of the CSA program, may wish to adopt the SLAT-proposed tool and require this information to be populated and linked to the SFD.

Providers' compliance records could be characterized by

- violations of standards considered most critical to protecting the health and safety of children;
- violations of standards considered most critical to ensuring program effectiveness;
- systemic deficiencies and license status;
- serious injuries and deaths of children; and
- staff-to-child ratios, staff qualifications, staff training, and staff turnover.

Much of this information is already contained in the information systems of State agencies, but a process would be needed to make this information consistent across agencies and link it to the SFD.

Once stakeholders determine the factors that should be included in the rating system, they would need to assign "weights" to these factors based on their relative importance as indicators of quality. Finally, stakeholders would need to determine the most useful manner of presenting this information. For example, this rating system could be fashioned as a "report card" on residential providers, with providers receiving "points" or "grades" depending on their performance in the different areas, which would be aggregated into an overall "grade."

This approach would require substantial collaboration among CSA stakeholders, and State licensing agencies would have to develop a standardized mechanism for submitting compliance information to OCS. However, time and resource investments in this process will enable Virginia to maximize its investment by ensuring that CSA participants receive the most cost-effective services. Furthermore, this step will also help the State to more fully realize the original intent of the CSA program because this system will improve the quality of services for Virginia's at-risk children and ensure that they are connected with the most appropriate and effective services available.

Recommendation (21). The Office of Comprehensive Services (OCS) should collaborate with the Secretary of Health and Human Resources and the Secretary of Technology to develop a comprehensive information system that would replace the Service Fee Directory and capture key compliance, performance, and financial information about residential services provided through the Comprehensive Services Act. OCS should report to the joint subcommittee studying the Comprehensive Services Act on the financial and staffing resources it may need to adequately develop and maintain this new information system.

Recommendation (22). The Office of Comprehensive Services, Office of Interdepartmental Regulation, Department of Social Services, Department of Education, Department of Juvenile Justice, and Department of Mental Health, Mental Retardation and Substance Abuse Services should work with the Virginia Information Technologies Agency to develop a standardized information system that will enable regulatory agencies to report licensing and compliance data on children's residential providers to the Office of Comprehensive Services.

CENTRALIZED NEGOTIATIONS COULD CREATE GREATER LEVERAGE AND FACILITATE RATE DIFFERENTIATION

Centralizing the rate negotiation and contracting processes could help Virginia control rates by exercising greater leverage than is presently attainable by individual localities. Currently, few localities are able to successfully negotiate lower rates with residential providers, often because they do not place a large enough number of children to warrant a “discount.” Furthermore, many localities lack either the staff or expertise to conduct successful negotiations, even if they can access more information about a provider.

By centralizing negotiations at the State or regional level, Virginia would utilize its full purchasing power and also place smaller localities in a fairer position. One statewide rate could be negotiated with each provider, broken out between various service components such as room and board or daily supervision. Every locality would then be charged the same rate for a given provider, although localities could also be given the option to conduct additional negotiations if they wish to attempt securing a lower rate.

In addition, centralized negotiations could be conducted by staff who possess the clinical skills to assess whether provider's rates are commensurate with the scope and quality of their services. CSA coordinators are generally expected to conduct rate negotiations, yet they may not possess the range of skills needed to successfully negotiate rates and evaluate cost-effectiveness. Finally, a centralized process would also be more efficient, because each residential provider would be negotiating with one party instead of 131 localities. Despite these potential benefits, many localities expressed concern about a centralized negotiation function. In particular, they cited the loss of control over the use of local funds that would accompany this shift. Furthermore, several localities reported having an effective negotiation process they wish to preserve.

CSA coordinators are generally expected to conduct rate negotiations, yet they may not possess the range of skills needed to successfully negotiate rates and evaluate cost-effectiveness.

Recommendation (23). The joint subcommittee studying the Comprehensive Services Act should examine the benefits and practicality of implementing a centralized process for negotiating rates with residential providers.

RATE SETTING MAY BE CONSIDERED

While the questionable cost-effectiveness of some facilities and the large profits realized by others are of concern, the magnitude of the problem may not warrant imposing more substantial reforms such as a formal rate control mechanism. Rather, improving access to information about the cost and quality of residential facilities may enable the market to better limit providers' ability to charge unnecessarily high rates. This approach would avoid imposing prescriptive mechanisms upon the majority of facilities for which this step appears unnecessary. However, it is possible that improving available information will not, by itself, be sufficient to ensure that facilities charge fair and justifiable rates for the services they offer. Consequently, the State may wish to consider the option of adopting a formal rate control mechanism. The rate control process followed by the state of Maryland appears promising and could be used in Virginia.

Better Information and Rate Negotiations May Not Entirely Resolve Market Inefficiencies

Although access to better information may improve local staff's ability to identify the most cost-effective providers, it will not necessarily ensure that all children are placed in these effective programs for several reasons. First, local programs may be in a weak negotiating position when case managers must make an emergency placement or find a facility willing to accept a difficult case. Second, only a subset of facilities charge rates that do not appear to be in line with the scope of services they offer, but there is no assurance that more providers will not decide to charge higher rates in the future absent formal rate control mechanisms. Finally, it remains to be determined whether individual localities can use more complete information to successfully negotiate lower, more appropriate rates with residential providers.

Virginia Could Explore Rate Setting Similar to Maryland's

Compared to the current free market approach, returning to a formal rate setting system could enable the State to secure the same rate across all localities, control the extent to which rates increase annually, ensure that providers charge more only if they offer more intensive services, and limit the profitability realized by some providers. However, a rate setting mechanism would have to

be designed carefully in order to ensure that these goals can be achieved without having unintended consequences, such as causing effective providers to exit the market.

The rate setting system used in Virginia prior to 1994 received much criticism for being burdensome and inflexible. In particular, a 1993 legislative committee report found the rate setting process lacking because

- rates were not tied to the quality of services, and having high costs was not necessarily indicative of high quality of care;
- there was little or no comparative analysis between the cost of participating providers; and
- there were several circumstances under which reimbursement caps did not apply.

Should the State wish to consider rate setting as an option in the future, it would be critical for these known shortcomings to be addressed. Maryland's process, which was adopted in 1999, seems to address most of these concerns.

In Maryland, each residential facility is assigned an individual rate paid by all referral sources who contract with that provider. This rate is determined based on how the facility compares to its peers with respect to the (1) intensity of services it provides and (2) cost of providing this service. Providers whose rates are commensurate with the scope of services they offer are categorized as "preferred" providers. Preferred providers receive the rate they requested, which is set at a level that allows them to fully cover their budgeted expenditures.

Providers whose rates are disproportionately high compared to their peers are categorized as "non-preferred" providers and cannot increase their rates over the previous year's level. As a result, providers can only increase their rates if they spend more in order to provide more intensive services or serve a more complex population. However, allowances are granted for expenses that are necessary to comply with regulatory requirements, even if those are not linked to greater intensity. This provision was incorporated to ensure that providers were given the proper financial resources to implement regulatory requirements. According to the manager of Maryland's rate setting division, when the cost of regulatory changes is excluded, the average increase in rates among children's residential facilities has remained below the Consumer Price Index since this process was adopted.

This system offers several advantages over the rate setting process formerly used in Virginia:

- Rates are examined in relationship with the intensity of services provided rather than strictly based on facilities' spending patterns.
- Each facility's rates and services are compared to those of peer providers to assess cost-effectiveness.
- All facilities are subject to the same process without exception.
- Each facility receives its own rate, which better reflects the variation in individual programs.

Greater Resources and Process Improvements Could Strengthen CSA Oversight

In Summary

Within the parameters of existing resource and information constraints, local CSA programs appear to develop the most appropriate service plans to address children's needs. When services are available, most children do not appear to be served in unnecessarily restrictive environments, and program staff generally promote the use of community-based services whenever possible. However, greater State guidance and resources for program administration could improve local ability to maximize limited staff time and resources and further ensure that CSA service plans most appropriately and cost-effectively address children's mental and behavioral health needs. In particular, additional State resources for local program administration could ensure better oversight of the State's large financial investment in the CSA program. Also, State guidance on how local programs can better prioritize the responsibilities of local CSA staff can further ensure that service plans are appropriate and cost-effective.

Previous chapters described critical gaps in the availability of certain services for at-risk children and their families, as well as limitations in local CSA programs' access to information on the availability and quality of those services. Within the parameters of these resource and information constraints, local CSA programs generally appear to develop the most appropriate service plans to address their clients' needs. In particular, most children do not appear to receive services in environments that are too restrictive for their emotional or behavioral needs.

However, improvements to local program structures could further ensure that children's needs are most appropriately and cost-effectively met through the CSA. Greater State guidance and resources for program administration could ensure that localities uniformly structure their local CSA programs to make the most efficient use of limited local agency staff resources, prioritize clients' service needs, and ensure that CSA service plans most appropriately and cost-effectively address those needs.

LOCAL CSA PROGRAMS GENERALLY DEVELOP APPROPRIATE SERVICE PLANS FOR ELIGIBLE CHILDREN

Based on interviews with CSA staff in 17 different local programs and an analysis of responses to a JLARC staff survey of all local CSA programs, local CSA programs generally seem to make service planning and eligibility decisions that are consistent with pro-

Research Methods

JLARC staff interviewed CSA coordinators, case managers, FAPT members, and CPMT members in 17 different local CSA programs. A map of the localities visited by JLARC staff is included in Appendix B. JLARC staff also surveyed all local CSA programs about the structure of their programs, factors that impact their service planning decisions, and challenges they experience in connecting children with appropriate services. The response rate was 81 percent. Finally, JLARC staff analyzed client-level data maintained by the State on recipients of CSA services.

Concerns that local programs are willfully overusing residential services seem unwarranted.

grammatic intent and that promote the well-being of children and their families. While some policymakers have expressed concerns about the increasing number of CSA children receiving services outside of their homes and communities, it appears that local CSA programs do focus on serving children in the most appropriate setting for their needs. Specifically, local program staff generally promote community-based services when it is safe and appropriate, and very few children are placed directly into residential care upon their initial enrollment in the CSA program. When children are placed in service settings that are more intensive or restrictive than necessary to meet their needs, this is primarily due to factors that are not within the control of local program staff.

Additionally, concerns that local programs are liberally interpreting certain CSA eligibility guidelines to secure services for children who might otherwise not receive services seem unwarranted. This does not appear to be a widespread practice and also does not have a substantial impact on CSA caseloads. However, JLARC staff analysis indicates that programs do spend more on services for children who enter the program in this way.

Local CSA Program Staff Focus on Providing Least Restrictive Services

According to §2.2-5200 of the *Code of Virginia*, the first objective of the CSA is to "ensure that services and funding are consistent with the Commonwealth's policies of preserving families and providing appropriate services in the least restrictive environment, while protecting the welfare of children and maintaining the safety of the public." Because an increasing number of CSA children have been receiving care in residential facilities, some State policymakers have expressed concerns that the CSA's policy of serving children in the least restrictive environment appropriate for their needs has not been universally promoted by local CSA program staff.

However, concerns that local programs are willfully overusing residential services seem unwarranted. Based on interviews with numerous CSA program staff in 17 different localities and responses to the JLARC staff survey of local CSA programs, it appears that local programs promote the use of community-based services for the majority of children, as long as these services are available in their communities. As discussed in Chapter 5, children who receive services that are either too intensive or restrictive for their needs generally do so because more appropriate community-based alternatives are not available.

The majority of program staff interviewed by JLARC staff reported a strong preference for community-based services versus residen-

tial care for CSA children and generally felt compelled to exhaust available community-based options before seeking a residential placement. Most local program staff reported that very few, if any, of their clients currently in residential care were placed there immediately upon their entry into the CSA program. Analysis of client-level data maintained by the Office of Comprehensive Services (OCS) indicates that 88 percent of the children who first entered CSA in FY 2006 were placed directly into community-based services, and only 12 percent were placed directly into residential care. Of those children receiving community-based services upon their initial enrollment in CSA in FY 2006, only one percent had subsequently been placed in residential care by the end of the fiscal year.

Federal Foster Care Policy

The federal government, through the Adoption Assistance and Child Welfare Act of 1980, requires that foster care plans be "designed to achieve placement in a safe setting that is the least restrictive and most appropriate setting available."

Emphasis on providing community-based services for children seems to be the result of federal and State policy. Nearly all survey respondents indicated that federal foster care policy and the CSA program's intent to place children in the least restrictive environment had a "high" or "moderate" impact on decisions to prioritize the use of community-based services.

However, the *Code of Virginia* emphasizes that while CSA services should be provided to children in the least restrictive environment possible, services should also be appropriate to protect children's welfare and maintain public safety. Interviews with local program staff and an analysis of survey results indicate that some CSA staff may be misinterpreting what is meant by "least restrictive services." Specifically, some local programs seem to be defaulting to the least restrictive available setting without fully considering if a more restrictive setting would better address the child's needs. While this does not suggest that programs are inappropriately placing children in insufficiently restrictive service settings, it does suggest that local programs may not be interpreting CSA policy in a manner that is consistent with programmatic intent. For example, nearly all survey respondents reported that within the past year, their program had placed children in community-based services even when suspecting that more restrictive or intensive services may eventually be required. Two-thirds of respondents estimated that this occurs in more than 10 percent of placements and 25 percent reported that it happened in more than 30 percent of placements.

Because misinterpretation could be detrimental to children's well-being, as well as the safety of the greater community, OCS may wish to clarify that CSA service plans should emphasize the least restrictive service setting that is most appropriate for a child's mental or behavioral difficulties, rather than the absolute least restrictive service setting available in the community.

Recommendation (24). The Office of Comprehensive Services (OCS) should take steps to clarify the meaning and intent of the CSA's policy of providing children with the most appropriate services in the least restrictive setting. Specifically, OCS should clarify that children may not uniformly have to be placed in the absolute least restrictive service setting available if their needs warrant a more restrictive level of care.

**"Mandated" vs.
"Non-mandated"**

Federal law mandates that states provide services to children in the state's custody or at risk of being placed in state custody and special education students who are eligible for private tuition assistance. Funding for these "mandated" children is not capped by the General Assembly. Funding for services for other "non-mandated" children, such as those referred from the juvenile justice or mental health systems, is capped.

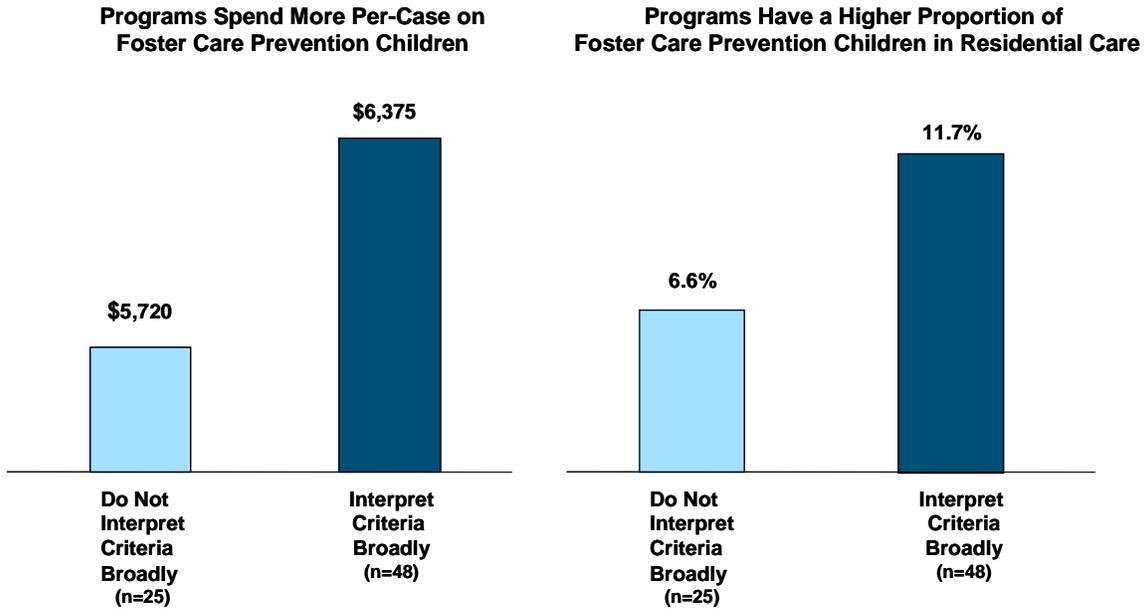
Eligibility Criteria for Foster Care Prevention Services Are Sometimes Interpreted More Broadly Than Intended

To be eligible for mandated funding of CSA services, a child must either be placed in State custody, require special education services, or need services to prevent foster care placement ("foster care prevention"). While eligibility criteria for the first two categories of CSA "mandated" children are fairly specific, what constitutes foster care prevention is less clearly defined. Local CSA program staff told JLARC staff that some localities use the flexibility of foster care prevention eligibility criteria to boost the number of non-mandated children receiving CSA services; while State funding for mandated children is unlimited, funding for non-mandated children is capped. JLARC's 1998 study of the CSA found that local staff in half of the 22 localities visited by JLARC staff had manipulated the foster care prevention eligibility guidelines in order to secure services for children who may have otherwise not been eligible for mandated CSA services.

Although some local program staff interviewed by JLARC staff reported that foster care prevention eligibility is sometimes used to obtain services for non-mandated children, this does not appear to be a widespread practice or have a substantial impact on CSA caseloads. Fourteen percent of the respondents to the JLARC staff survey of local programs reported that they sometimes interpret foster care prevention eligibility more broadly than intended by State policy, and most reported doing so in less than one-third of foster care prevention cases. Across the State, foster care prevention is the smallest category of CSA eligibility, accounting for 15 percent of all CSA cases. Moreover, some local programs have instituted "gate keeping" systems to ensure that foster care prevention-eligible children legitimately meet those eligibility criteria.

However, JLARC staff analysis suggests that localities that report interpreting foster care prevention more broadly than intended tend to have higher overall per-child expenditures for foster care prevention children and a higher proportion of foster care prevention children in residential care (Figure 43). One explanation for this association could be some localities' practice of using foster

Figure 43: Broad Interpretations of Foster Care Prevention Eligibility Criteria Lead to Higher Costs



Note: JLARC staff controlled for the severity of cases and this did not affect the association between per-child costs, proportion of foster care prevention children in residential care, and program staff's interpretation of foster care prevention eligibility criteria.

Source: JLARC staff analysis of local CSA program survey responses and OCS FY 2006 client-level expenditure data (first three quarters).

care prevention funding to pay for short-term residential placements in which the facility reportedly provides in-depth mental health assessments on children. According to State DSS staff, this is an acceptable use of foster care prevention funds. In 2006, the average daily rate for residential facilities that provide diagnostic services is \$297, compared to \$241 for facilities that do not offer this service.

ADDITIONAL STATE RESOURCES AND TRAINING COULD IMPROVE ACCOUNTABILITY AND EFFICIENCY IN LOCAL CSA SERVICE PLANNING

Because localities have been granted substantial discretion in their local implementation of the CSA, program administration varies significantly statewide. Whereas local flexibility in the implementation of the CSA enables localities to tailor their service delivery to unique local contexts, certain approaches to local program implementation could facilitate better, more cost-effective service decisions. Given the acute and complex needs of the children and families served by the CSA and the fact that the average cost to serve a single CSA child in FY 2005 was more than \$21,000 (excluding Title IV-E and Adoption Assistance funding), a strong local

management structure should be in place to ensure that CSA service plans are appropriate and cost-effective. However, unequal ability to hire staff who are dedicated to managing the local CSA program has resulted in ineffective approaches to program management and oversight. Additional State resources for and guidance on local program administration could facilitate better oversight of the State's large financial investment in the CSA program by reducing unnecessary expenditures and ensuring that CSA children and their families are more consistently connected with the most appropriate services.

CSA Program Staff Are Critical to Facilitating Program Effectiveness

The State requires each locality to establish two separate multidisciplinary bodies to oversee and manage the delivery of services to CSA children: the Community Policy and Management Team (CPMT) acts as the fiscal agent of the program and the Family Assessment and Planning Team (FAPT) assesses the specific needs of CSA children and families and develops and oversees a plan of care to address those needs. Within these broad guidelines, the specific roles of these two groups vary greatly across localities.

CPMT and FAPT members often balance their CSA duties with other responsibilities within their own agencies and may be unable to provide sufficient oversight of the CSA program. Therefore, CSA coordinators and their support staff are often the only staff solely dedicated to administering the CSA program. Yet, limited State and local funding for program administration has prevented some localities from hiring enough program staff to operate an effective and efficient local program. The author of a recent cost containment study conducted for one local CSA program made this observation, which could be applied to most localities visited by JLARC staff:

One glaring weakness [of the local program] is that there appears to be no one in charge and a very unclear chain of command. FAPT and CPMT members seem to do their best at their respective meetings, but there seems to be no real overall ownership of the process and mutual responsibility for assessment, planning, and evaluation....This lack of clear leadership and authority is having a direct impact on making improvements to the CSA system and cost containment efforts.

The State has acknowledged the administrative burden of certain elements of the CSA program and allocates limited funding for local program administration. According to OCS and a majority of survey respondents and local program staff interviewed in all 17

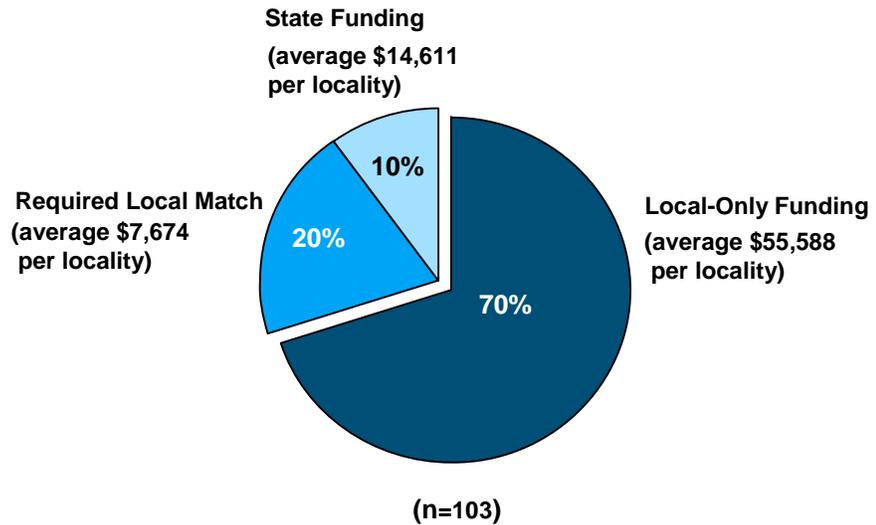
localities visited by JLARC staff, State General Fund allocations for local administrative costs are inadequate to support well-managed and accountable local programs. As a result, most programs primarily rely on local government funding to subsidize program administration costs. This appears to have resulted in very disparate, and sometimes ad hoc, approaches to local program administration.

State and Local CSA Stakeholders Report Inadequate State Funding for Program's Local Infrastructure. The size of each locality's administrative funding allocation remains based upon their 1997 expenditures and may not reflect the current demands placed on their local programs. Moreover, the State's contribution to local administrative funding has been capped at approximately \$38,000 since 2000 (or \$50,000 when including the required local match), despite increasing caseloads and additional demands that have been placed upon local programs by the State. Only about one-quarter of all localities received more than \$10,000 from the State for their administrative costs in FY 2006. FY 2006 administrative funding for local program administration, as well as funding granted to the Office of Comprehensive Services, represents less than one percent of total FY 2005 CSA service expenditures. In comparison, administrative funding for the Department of Medical Assistance Services represents two percent of all FY 2005 Medicaid expenditures.

The majority (56 percent) of respondents to JLARC's survey of local CSA staff reported that administrative funding is inadequate to administer most aspects of their local programs, which could lead to unnecessary expenditures. In particular, respondents indicated that the lack of funding impairs their ability to negotiate contracts with service providers, monitor CSA clients' outcomes, conduct thorough utilization management and review activities, and identify alternative funding sources. Many local CSA programs rely on local funding to cover most of their administrative responsibilities. Based on FY 2006 administrative budget figures reported by local CSA staff and an analysis of total administrative budgets reported by local programs, it appears that State funding accounts for 20 percent of all local CSA administrative costs (Figure 44). Localities contributed, on average, an additional \$56,000 over and above the required local match in FY 2006 compared to an average State share of \$14,611.

Funding Should Be Made Available to Allow All Local Programs to Employ a CSA Coordinator. Because of the significant investment the State and localities are making in the CSA, proper oversight of the program is critical. In most localities, this oversight is conducted by the CSA coordinator because FAPT and CPMT members

Figure 44: Localities Finance 80 Percent of CSA Administrative Costs



Note: These figures, including State funding, reflect the administrative expenditures for only those localities that responded to the JLARC staff survey of local CSA programs (n=103). When including nonrespondents, localities received an average of \$11,885 from the State and had a required local match of \$7,491.

Source: JLARC staff analysis of local CSA program survey responses and OCS data on FY 2006 administrative funding allocations.

have other responsibilities within their own agencies. However, limited funding for program administration has kept some localities from hiring a coordinator, and some localities have had to rely on a part-time staff person or share a coordinator position across multiple localities. Only one-third of all localities responding to the JLARC staff survey of local CSA programs have a full-time CSA coordinator (Figure 45).

In one locality, CPMT members who serve on multiple CPMTs reported that, in their experience, the management of local programs that did not have a CSA coordinator was "disorganized and fragmented." A FAPT member from another locality stated that "CSA is nobody's priority except the CSA coordinator's." The following two examples further illustrate the benefit to local program management of a CSA coordinator:

Case Studies

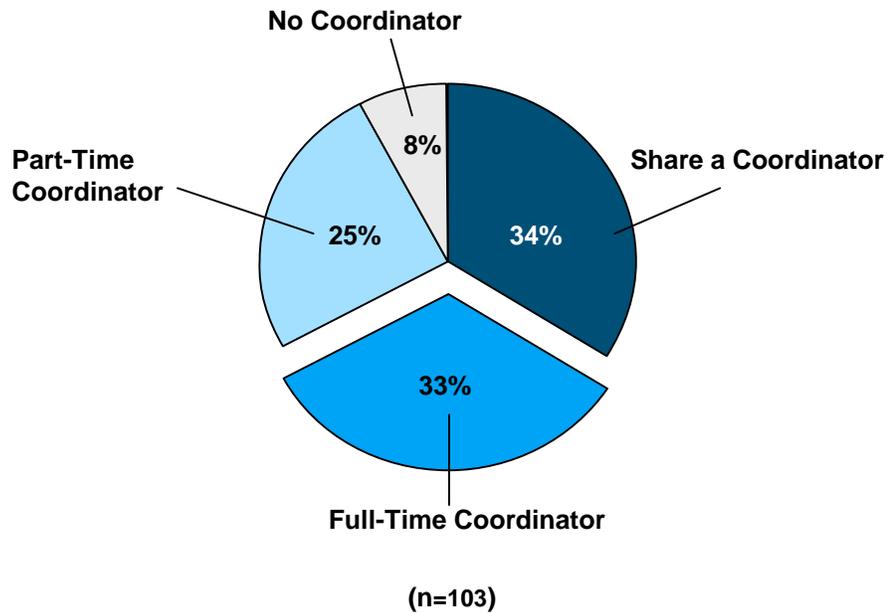
One CSA program in Southwest Virginia only has a part-time coordinator. Both FAPT and CPMT members told JLARC staff that the coordinator's position is critical to their ability to efficiently manage an effective CSA program, and that the recent addition of this position has significantly improved program operations. While she is only paid

to work 20 hours per week, she often works from home without being compensated because of the administrative demands of her position. Her responsibilities include monitoring the status of every client, attending every FAPT and CPMT meeting, and acting as the liaison between the FAPT and CPMT.

* * *

JLARC staff visited a local program that does not currently employ a CSA coordinator. In this locality, the program's administrative responsibilities fall primarily to one of the FAPT members. The absence of a CSA coordinator has resulted in poor information-sharing between the FAPT and CPMT, which has contributed to mutual distrust between the two bodies and may undermine the program's effectiveness.

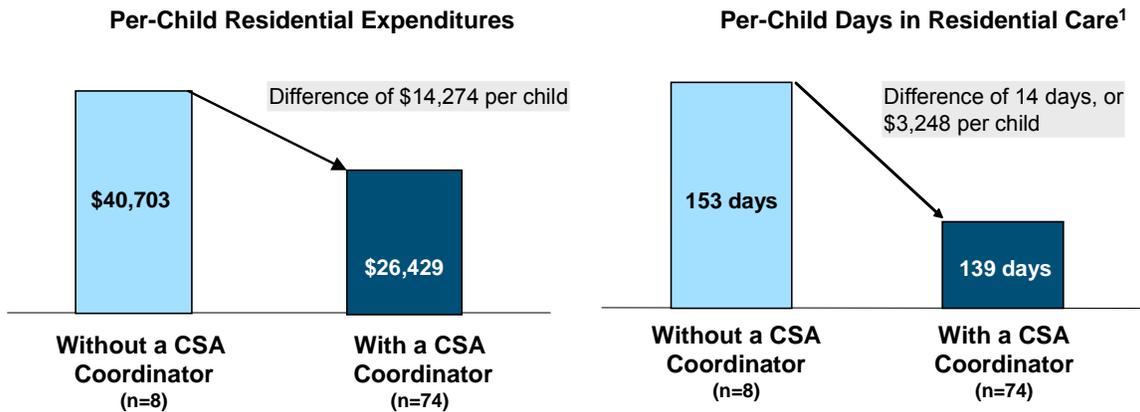
Figure 45: Only One-Third of Localities Have a Full-Time CSA Coordinator



Source: JLARC staff analysis of local CSA program survey responses.

In addition to local reports about the benefits of having a CSA coordinator, JLARC staff analysis of client-level CSA expenditure data show that having a staff person dedicated to administering the CSA program may be associated with certain indicators of a well-managed and cost-effective local CSA system. In particular, local programs with a CSA coordinator tend to spend \$14,000 less per child for residential care, on average (Figure 46). This is partially because the average length of stay in residential facilities is

Figure 46: Localities With a CSA Coordinator Spend Less on Residential Services



Note: JLARC staff controlled for the severity of cases, and this did not affect the association between per-child residential cost and the presence of a CSA coordinator.

¹The cost difference in the second graph is based on the average daily cost per child in residential care of \$232 (FY 2006). This figure represents a maximum cost savings because it assumes that a child is discharged into the community with no other services. Because community-based services are not always paid for or provided on a daily basis, it is not possible to compare per-day costs of residential versus community-based services.

Source: JLARC staff analysis of local CSA program survey responses and OCS FY 2006 client-level expenditure data (first two quarters).

14 days shorter in programs that employ a CSA coordinator than in programs that do not. This could occur because CSA coordinators often conduct utilization management and review on residential cases to determine whether children are ready to transition to a less restrictive environment. At an average of \$232 per day, reducing a child's residential stay by 14 days equates to an average savings of \$3,200 per child.

Local governments that have chosen to fund the unmet administrative needs of the program may not always be able to do so if fiscal priorities change.

More than one-third of the CSA programs responding to the JLARC staff survey received no funding for program administration from their local governments besides the required local match. Several local agency staff reported that because their local government officials are already obligated to fund the required local match for "mandated" CSA services, they are reluctant or unwilling to appropriate any additional funds for other CSA-related purposes. In addition, local governments that have chosen to fund the unmet administrative needs of the program may not always be able to do so if fiscal priorities change. Therefore, to ensure that all localities are able to hire staff to adequately oversee the CSA program on behalf of their locality and the State, the Governor may wish to request funding to increase the State's allocation for local CSA administrative costs.

Based on an analysis of CSA programs' current administrative budgets, the statewide average administrative budget reported for programs that employ a full-time coordinator and no other staff is

approximately \$55,000, including both salary and benefits. The specific amount required to compensate a qualified CSA coordinator will vary by locality based on cost-of-living differences. In addition, some localities may not have a large enough caseload to justify hiring a full-time coordinator. Of the localities that responded to the JLARC survey, the smallest program that has a full-time coordinator position had a total caseload of 32 in FY 2005. For localities without a large enough caseload to require the support of a full-time coordinator, the Governor may wish to allocate an amount sufficient to enable these localities to hire at least a part-time coordinator. This might encourage smaller localities to pool their administrative funding toward hiring a shared coordinator. Under this proposal, 92 localities (those with caseloads greater than or equal to 32 children in FY 2005) would receive \$55,000 on average for the salary and benefits of a full-time coordinator, and 39 localities (those with caseloads of less than 32 children) would receive \$27,500 on average for a part-time coordinator.

This proposal would increase the current amount of administrative funding by \$3.8 million, to a total of \$6.1 million (Table 28). Based on the current local match requirements, \$2.5 million of this increase would be paid by the State and \$1.3 million by localities.

Table 28: Fiscal Impact of Proposed General Fund Increase for Local Program Administration

	Proposed	Current	Difference
Total	\$6,132,500	\$2,363,089	\$3,769,411
State Share	4,047,450	1,556,959	2,490,491
Local Share	2,085,050	806,130	1,278,920 ¹

Note: Fiscal impact is based on 92 localities with caseloads greater than or equal to 32 children receiving \$55,000 on average for a full-time CSA coordinator position and 39 localities with caseloads smaller than 32 children receiving \$27,500 on average for a part-time coordinator position.

¹Based on survey responses, 60 percent of local programs already receive discretionary funding from their local governments that would offset this additional required local contribution. This increase will most significantly impact the 40 percent of local programs that do not currently receive any discretionary funding from their local governments.

Source: JLARC staff analysis of OCS data on FY 2006 funding for local program administration.

Based on an analysis of local program survey responses and interviews with CSA coordinators around the State, CSA coordinator expertise and program responsibilities appear to vary widely. For example, whereas some coordinators have extensive business and finance expertise, others are more skilled in social work. The extent to which coordinators are involved in the details of the local CSA system also varies greatly. For example, ten coordinators responding to the JLARC staff survey reported either rarely or only occasionally attending FAPT meetings. Further, some local pro-

grams visited by JLARC staff used their CSA coordinator in a more clerical capacity, despite the potential for this position to be used for activities that may bear a more substantial impact on the program's cost-effectiveness, such as conducting utilization management and review, tracking children's outcomes or identifying ways to contain program costs. OCS may therefore wish to develop a model CSA coordinator job description to assist local programs in prioritizing the responsibilities of their coordinators and maximize the State's investment in local CSA program administration.

Recommendation (25). The Governor may wish to consider increasing the appropriation for local CSA program administrative funding by \$2.5 million to enable local programs to employ a CSA coordinator without relying on discretionary local funding. Local allocations should be adjusted for differences in caseload.

Recommendation (26). The Office of Comprehensive Services should develop a CSA coordinator job description to guide localities in prioritizing their coordinators' responsibilities toward activities that will maximize program effectiveness and minimize spending.

Additional Resources for Local Utilization Management and Review May Help Contain Program Costs and Improve Child Outcomes.

Since 1997, the General Assembly has required that each local CSA program implement a utilization management and review (UM/UR) process to regularly assess the appropriateness of FAPT referrals to residential settings. In addition to focusing UM/UR on specific cases to ensure that children are receiving the most appropriate and cost-effective services, OCS encourages local programs to review the effectiveness of their broader system of service delivery. To this end, OCS suggests that localities collect and analyze data on

- recidivism rates by diagnosis or provider type,
- average length of stay by diagnosis or provider type,
- family satisfaction with services, and
- changes in children's functioning based on a standardized assessment tool.

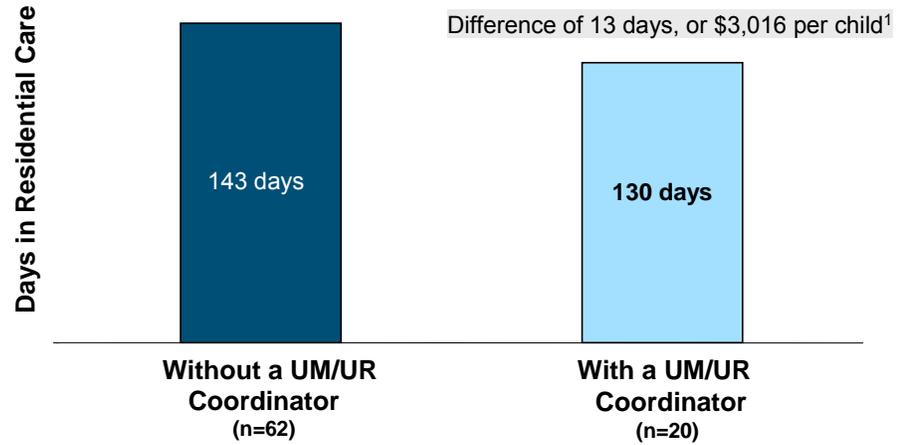
It appears that some child welfare and cost containment benefits are associated with having a UM/UR staff person employed at the local level. JLARC staff analysis of client-level CSA expenditures indicates that localities with a staff person dedicated to UM/UR activities tend to have shorter per-child residential stays (Figure 47). Reducing the average length of stay in residential care by only one day could generate annual savings of \$1.2 million statewide.

Utilization Management and Review

OCS defines Utilization Management as "a set of techniques used by or on behalf of purchasers of health and human services to manage the provision and cost of services through systematic data driven processes."

Utilization Review is defined as "a formal assessment of the necessity, efficiency, and appropriateness of the services and treatment plan for an individual."

Figure 47: Children in Programs With a UM/UR Coordinator Spend Less Time in Residential Care



Note: JLARC staff controlled for the severity of cases, and this did not affect the association between duration of residential stay per child and the presence of a UM/UR staff person.

¹The cost difference noted above is based on the average daily cost per child in residential care of \$232 (FY 2006). This figure represents a maximum cost savings because it assumes that a child is discharged into the community with no other services. Because community-based services are not always paid for or provided on a daily basis, it is not possible to compare per-day costs of residential versus community-based services.

Source: JLARC staff analysis of local CSA program survey responses and OCS FY 2006 client-level expenditure data (first two quarters).

Having a UM/UR staff person has improved the quality of services provided to CSA children, giving localities the "eyes and ears" to monitor service delivery more closely.

According to program staff in several localities, having a UM/UR staff person has improved the quality of services provided to CSA children, giving localities the "eyes and ears" to monitor service delivery more closely. Staff from one local program observed that because their program has a UM/UR staff person, providers tend to be more accountable in their service delivery than they are with clients from other jurisdictions. Because UM/UR staff often serve as the program's primary liaison to the provider community, this position has also given case managers, the FAPT, and the CPMT a resource to differentiate between providers based on quality.

The following examples illustrate how local programs are using UM/UR to ensure that CSA clients are receiving the most appropriate and cost-effective services:

Case Studies

One local program has hired a UM/UR staff person through the local CSB. The coordinator has created a separate FAPT "docket" for cases that meet specific criteria, including children who have been in residential care for longer than 18 months, children who are transitioning from residential care to community-based services, and those who have ex-

perienced two or more placement disruptions. The UM/UR staff person reviews cases that meet these specified criteria and is also available for consultation with case managers and FAPT on placement decisions for any case.

* * *

One southwestern Virginia program has a UM/UR staff person who assists case managers in prioritizing the needs of children who are being recommended for residential care. This helps to refine children's service plans before they are presented to FAPT for discussion. This process has reportedly resulted in identifying alternatives to residential care.

* * *

One Northern Virginia program has two UM/UR staff who are responsible for conducting in-depth reviews of the needs and service plans of children who are referred for UM/UR. This may entail conducting on-site interviews of children's providers, reviewing provider records, and attending FAPT meetings. Criteria for referral to UM/UR include extended lengths of stay in residential care, residential and TFC placements that are more expensive than average, and placements in other parts of the State. The stated goals of this program's UM/UR efforts include reducing the duration and cost of residential care, providing a clinical assessment of the appropriateness of service plans, providing quality assurance of residential placements, and ensuring accountability and consistency across cases.

One-quarter of survey respondents indicated that their current administrative budgets do not allow them to effectively conduct utilization management and review.

Despite the potential financial and service delivery benefits that could be generated by a UM/UR process, one-quarter of survey respondents indicated that their current administrative budgets do not allow them to effectively conduct UM/UR. Moreover, three quarters of the programs responding to the JLARC survey did not report having a staff person dedicated to UM/UR apart from the CSA coordinator.

The State has recognized that not all localities will be able to conduct sound UM/UR activities on their own, particularly given limited available funding for local program administration. Therefore, it has given local programs the option of contracting with a third party—currently OCS—to perform their UM/UR. This OCS role is currently limited in scope but holds promise for facilitating cost-effective and appropriate service decisions and ensuring greater State oversight of local CSA program operations. OCS is currently available only to those localities that previously contracted with the State's third-party provider of UM/UR (West Virginia Medical

Institute) and reviews only non-Medicaid residential placements. At the present time, only 46 localities contract with OCS for UM/UR.

The State's ability to provide UM/UR for local CSA programs is critical given the difficulty some localities will face in recruiting and retaining staff with the clinical skills necessary to evaluate the appropriateness of service decisions. There is limited data, however, to determine the effectiveness of the OCS UM/UR function because OCS first assumed this role in July 2006. Yet, according to OCS staff, improving their capacity to provide on-site technical assistance and training on effective UM/UR and expanding the scope of their case review would allow them to better facilitate cost-effective and appropriate service decisions and ensure greater State oversight of local CSA program operations.

The OCS, through a UM/UR steering committee made up of State and local agency staff, is exploring how to expand the State's UM/UR role. OCS staff have maintained, however, that even with an expanded OCS role, localities can more effectively conduct UM/UR with their own in-house or regional staff. According to these staff, localities should be given the resources to conduct their own UM/UR, and OCS staff should focus on providing technical assistance and oversight and only conduct case review on a limited basis. The State should therefore consider the following options for improving local capacity to conduct UM/UR.

First, additional administrative funding could be made available to allow all local programs to conduct UM/UR using their own staff. The annual salary and benefits for a UM/UR staff person in one locality visited by JLARC staff is \$60,000. This amount seems reasonable given the level of clinical expertise required of this position. Allocating \$60,000 per locality would likely ensure that localities are able to afford the salary and benefits of one full-time staff person to conduct UM/UR. This amount could be adjusted to reflect differences in cost-of-living in Northern Virginia and could also be reduced for localities with smaller caseloads that only need a part-time UM/UR staff person. Those localities that qualify for reduced administrative funding to hire a part-time CSA coordinator could also qualify for reduced funding to hire a part-time UM/UR staff person. This funding could then be combined at the local level to hire one full-time person to fulfill both roles. Smaller localities could also be encouraged to pool their UM/UR funding allocations to hire shared full-time UM/UR staff. To be consistent with the funding structure for CSA coordinators, localities that choose to hire a UM/UR staff person could be required to provide a local funding match.

If additional funding is not made available to allow local programs to hire their own UM/UR staff, consideration should be given to expanding the scope of UM/UR conducted by OCS. Specifically, OCS should consider taking on the following additional responsibilities, in order of first priority:

- Facilitate training all localities on developing the most appropriate and cost-effective service plans for children receiving services through the CSA program;
- Expand its case review to focus not just on the appropriateness of services, but also the cost of services;
- Provide UM/UR technical assistance and support to all localities, not just those who previously contracted with West Virginia Medical Institute; and
- Expand its UM/UR case review to include non-residential services, in particular therapeutic foster care and special education day schools.

The OCS and the State Executive Committee should evaluate OCS' current capacity to take on these additional responsibilities and determine what additional resources this expanded role will require. Currently, two full-time staff are responsible for reviewing non-Medicaid residential cases for only 46 localities, although a total of 72 are eligible to use OCS for this purpose. While OCS staff are therefore not currently reviewing the maximum number of cases these positions were designed to manage, if OCS were to provide UM/UR for all localities that currently do not have a staff person for this purpose, at least 44 additional localities would be eligible to contract with OCS. Additionally, expanding case review to non-residential cases, adding an on-site training component, and focusing on cost-effectiveness as well as the appropriateness of services would further increase the administrative demands placed on OCS.

Expanding the State's UM/UR role will therefore likely require additional administrative funding. In considering this option for expanding local capacity to conduct UM/UR, the General Assembly may wish to require that OCS report the findings of its State Sponsored Utilization Management Steering Committee to the joint subcommittee that was directed to review the CSA along with JLARC (SJR 96, 2006). Specifically, this report should include an estimate of the additional administrative funding needed for OCS to assume the additional UM/UR responsibilities listed above. Table 29 summarizes advantages and disadvantages of these options.

Table 29: Advantages and Disadvantages of Approaches to Increasing Local Capacity to Conduct Utilization Management and Review

Additional Funding to Localities to Allow Local Programs to Hire Their Own UM/UR Staff		
Advantages	Disadvantages	Fiscal Impact¹
<ul style="list-style-type: none"> • Knowledge of local context and individual cases • More accessible for consultation • Greater interaction with service providers • Actively involved in service plan development • Gives locality in-house resource • Can tailor UM/UR to unique local contexts • Gives localities greater sense of ownership over UM/UR, which increases likelihood of positive impact 	<ul style="list-style-type: none"> • Local disadvantages in hiring and retaining qualified staff • Some may not need a UM/UR staff person separate from the CSA coordinator • May foster inconsistent approaches to UM/UR • May foster duplicative interaction with provider community 	<p>\$6.7 million (\$4.4 million State and \$2.3 million local) for localities to afford the salary and benefits of a UM/UR position, adjusted for differences in cost of living and for localities with smaller caseloads to hire a part-time UM/UR staff person</p>

Expanding Scope of OCS UM/UR Function		
Advantages	Disadvantages	Fiscal Impact
<ul style="list-style-type: none"> • Consistency in how UM/UR is conducted • Centralization of UM/UR is more efficient • Can offer technical assistance and training • Improved State access to information necessary for ongoing program evaluation and improvement • OCS better positioned to ensure accountability 	<ul style="list-style-type: none"> • Less familiar with cases and local contexts • UM/UR would occur after the fact • Case review focus could limit consultative and training role • Does not fully address disparity in local resources • Future OCS leadership could use UM/UR to deny CSA funding to localities 	<p>\$175,000 if two additional UM/UR staff were hired at OCS</p>

¹Fiscal impact is based on 92 localities with caseloads greater than or equal to 32 children receiving \$60,000 on average for a full-time UM/UR staff person and 39 localities with caseloads smaller than 32 children receiving \$30,000 on average for a part-time UM/UR position.

Source: JLARC staff interviews with State and local OCS program staff.

CPMTs Should Shift Their Focus Toward Program Oversight and Away from Individual Case Review

Accountability in CSA service planning could be enhanced by more clearly defined expectations of the CPMT role. Many of the CPMTs interviewed by JLARC staff appeared unsure of how to add the greatest value to the CSA system. As a result, some local programs may lack the strategic vision and oversight capability to maximize the effectiveness and minimize the cost of CSA services. Whereas the *Code of Virginia* grants specific responsibilities to the FAPT, such as assessing children's needs and developing and implementing individualized service plans to meet those needs, the *Code* does not as clearly define the responsibilities of the CPMT. Rather, the *Code* more broadly states that CPMTs are to focus primarily on developing local policies for the provision of services to CSA clients and their families, coordinating community-wide planning regarding the development of services needed by CSA children, and managing CSA funding. As a matter of course, CPMTs appear to spend the majority of their time reviewing individual cases that have already received FAPT input.

Ensuring that CPMTs focus on fulfilling a more strategic role may improve localities' ability to contain costs. JLARC staff analysis of CSA client-level expenditure data indicate that CPMTs which meet at least once per month for at least two hours, whose attendees regularly include representatives from those local agencies required by the *Code*, and which have undertaken at least three activities to control costs and ensure the provision of quality services spent approximately \$1,800 less per child across all services and approximately \$6,500 less per child in residential care in 2006 compared to other localities. Moreover, CPMTs visited by JLARC staff that were more proactive in policy-setting and overall program oversight also tended to have lower per-child expenditures and a smaller proportion of children receiving care in a residential setting.

Aside from making some FAPTs more attentive to the fiscal ramifications of their service plan recommendations, the case review function assumed by most CPMTs may be their least effective role because it appears to have little impact on the services provided to CSA children. Of the 60 percent of local programs whose CPMTs review every CSA-funded case, the majority rarely make changes to the service plans developed by FAPT. Members of several CPMTs interviewed by JLARC staff reported that they are unlikely to make changes to FAPT service plans because they trust the FAPT members' decisions.

In an attempt to more effectively use CPMT members' time and expertise, some localities have limited their role in individual case

review. For example, CPMTs in one-third of the programs responding to the JLARC survey only review cases that meet certain criteria, frequently tied to expenditure or service need thresholds. Other local programs visited by JLARC staff have granted funding authority to the FAPT for some or all cases or have created a multidisciplinary team apart from the CPMT to review FAPT recommendations. The following examples show how some local programs have chosen to limit their CPMT's focus on individual case review in order to focus on broader programmatic issues:

Case Studies

One CPMT only reviews those cases for which there is no FAPT consensus about the service plan or when a case involves a noncustodial placement. The CPMT has chosen to focus on noncustodial cases to ensure that the local agencies are complying with federal foster care planning requirements, that there is a high level of family participation in the service plan, and that families are not using noncustodial placements prematurely. This reportedly allows the CPMT to focus its time on developing policies for program administration, reviewing CSA-related legislation, and engaging in service planning activities for the community.

* * *

Another CPMT has created two subcommittees – one that focuses on fiscal management and one that focuses on policy setting. The fiscal subcommittee is responsible for approving CSA funding for services and only reviews cases that are over a certain expenditure threshold. The policy subcommittee focuses on reviewing and setting policies for CSA program management. Prior to restructuring their approach, CPMT members said that they never had time to examine or address broader programmatic issues.

* * *

Another CPMT only reviews cases if the CSA coordinator feels that their input is needed, particularly in identifying alternative services to what FAPT or the case managers may have considered. The CPMT is also given a written update on the progress of all children in residential care toward returning to the community. CPMT members reported that this has allowed them to focus on "the bigger picture" and they have been able to set aside every other meeting for evaluating children's progress toward their long-term objectives.

Several local program staff reported that because CPMT members tend to be either agency directors or serve in a supervisory role in their respective agencies, they have little time to devote to the CSA. Given these constraints, as well as the limited value of CPMT case review, the OCS should encourage CPMTs to focus more of their time and resources on policy development and program improvement and less on reviewing individual CSA cases. In particular, CPMTs should be encouraged to develop policies to improve the ability of FAPTs and case managers to identify and purchase the most cost-effective services for their clients. OCS should also directly assist individual localities in identifying how their CPMTs can best contribute to the administration of an efficient and effective local CSA system. To this end, best practices could be shared across localities. For example, some CPMTs have

- developed a list of preferred service types that FAPTs should consider,
- identified the criteria that providers must meet in order to receive CSA funding,
- developed guidelines for FAPTs to consider when arranging for residential care, and
- taken steps to address gaps in the local continuum of care available for CSA clients.

In addition to providing on-site assistance with prioritizing CPMT roles and responsibilities, OCS could arrange a training course on this topic.

Localities should, however, retain their current flexibility in allowing CPMTs to conduct reviews of individual CSA cases. While CPMTs appear to make few changes to individual service plans and could best focus their time and expertise on other activities, the potential for CPMT to review individual CSA service plans could make FAPTs more cognizant of service costs and program expenditures.

Recommendation (27). As part of its efforts to train Community Policy and Management Team (CPMT) members on their roles and responsibilities within the State and local CSA system, the Office of Comprehensive Services (OCS) should encourage CPMTs to focus more of their time and resources on fiscal management, policy development, and program improvement and less on reviewing individual CSA cases. OCS should also assist individual localities in identifying how their CPMTs can best contribute to the administration of an efficient and effective local CSA system.

FAPTs May Wish to Concentrate Efforts on Highest Cost and Most Complex Cases

FAPTs are primarily responsible for developing and reviewing children's individualized service plans, with a focus on ensuring that services are appropriate and cost effective. Because it instills greater accountability among local agency staff, the FAPT process appears to be largely responsible for the fact that programs generally make appropriate service decisions for CSA clients. Some local program staff interviewed by JLARC staff predicted that if it were not for FAPT oversight, more children would be placed in unnecessarily restrictive service settings.

Some local program staff interviewed by JLARC staff predicted that if it were not for FAPT oversight, more children would be placed in unnecessarily restrictive service settings.

Most local program staff interviewed in 17 different localities generally felt that FAPTs benefit the overall CSA system in the following ways:

- ensuring that children's needs are assessed and addressed from a multidisciplinary perspective,
- serving as a deterrent to potentially inappropriate service placement decisions by case managers,
- identifying alternative funding sources to CSA,
- serving as a resource for case managers to identify potential service providers, and
- instilling greater accountability among service providers.

In addition, local CSA stakeholders indicated that FAPTs are particularly valuable in developing service plans for children with complex needs.

Based on JLARC staff's observations, local programs could make more efficient use of the staff time and expertise that are dedicated to the FAPT process. Specifically, local programs could identify criteria that cases must meet to necessitate FAPT review. Focusing FAPT resources on the most complex and expensive cases could have cost containment benefits. Although the State requires that the teams develop cost-effective service plans, all FAPTs are not equally cognizant of the financial ramifications of their service planning and placement decisions. Moreover, while FAPTs report that they tend to rely on their CPMT to ensure that service plans are cost effective, most CPMTs interviewed by JLARC staff indicated that they trust the FAPT's decisions. Focusing FAPT review on complex and high-cost cases could instill a greater awareness of the importance of minimizing program costs among the teams.

Focusing FAPT resources on the most complex and expensive cases could have cost containment benefits.

FAPTs Add Little Value to Certain Types of CSA Cases. Whereas most local program staff reported that the FAPT process is a cor-

nerstone of local programs' effectiveness, they also indicated that certain types of cases do not benefit from the team's review. Specifically, cases that involve an individualized education plan (IEP) generally cannot be altered by FAPTs because federal policy requires that the components of a child's IEP be implemented. In addition, cases involving children who have less complex service needs may not warrant extensive FAPT review.

Numerous FAPT members expressed frustration that although they devote much of their time to the FAPT process, they do not contribute significantly to certain types of cases. Members of one FAPT told JLARC staff that they feel like they are more often looked to as "a group to come to for money" rather than the brainstorming body of experts they would like to be.

Survey analysis confirms that local agencies devote a great deal of their staff resources to the FAPT process; on average, six local agency staff attend FAPT meetings and teams meet an average of 12 hours each month. Moreover, nearly one-quarter of respondents indicated that their locality has more than one FAPT. In many localities, given the amount of staff time dedicated to serving on FAPTs, the FAPT process as it is currently structured may not be the most efficient use of local agency staff resources.

State Law Does Not Require That All CSA Cases Undergo FAPT Review. The *Code of Virginia* already gives local CPMTs the flexibility to select the types of cases that must be reviewed by their FAPT. The *Code* stipulates that localities may employ a multidisciplinary case review team as an alternative to the FAPT process, as long as this alternative process is approved by the CSA's State Executive Council (SEC). This gives local programs the flexibility to exclude some cases from FAPT review based on locally defined criteria. According to CSA policy, these multidisciplinary teams are accountable to local CPMTs and must follow all policies pertaining to the CSA. Despite this flexibility and local FAPTs' frustration over the limited value they add to certain cases, nearly half of all local programs have FAPT review every CSA-funded case. It appears, therefore, that staff time and resources dedicated to the FAPT process are not being optimized in many localities.

The following examples illustrate how two localities have attempted to improve the efficiency and effectiveness of their FAPT process by using a multidisciplinary review process apart from FAPT or by limiting the team's review to specific types of cases:

Case Studies

One FAPT has chosen to review only those cases that are expected to exceed \$3,000 per month for community-based services, \$4,000 per month for special education/private day

school services, and \$7,000 per month for residential care. Alternative multidisciplinary teams composed of staff from the relevant agencies review the service plans of cases with expenditures below these thresholds. According to program staff, this decision was made to manage the program's growing caseload and to focus FAPT resources on the most significant cases. The FAPT conducts quarterly "paper reviews" of those CSA cases that remain under the expenditure threshold.

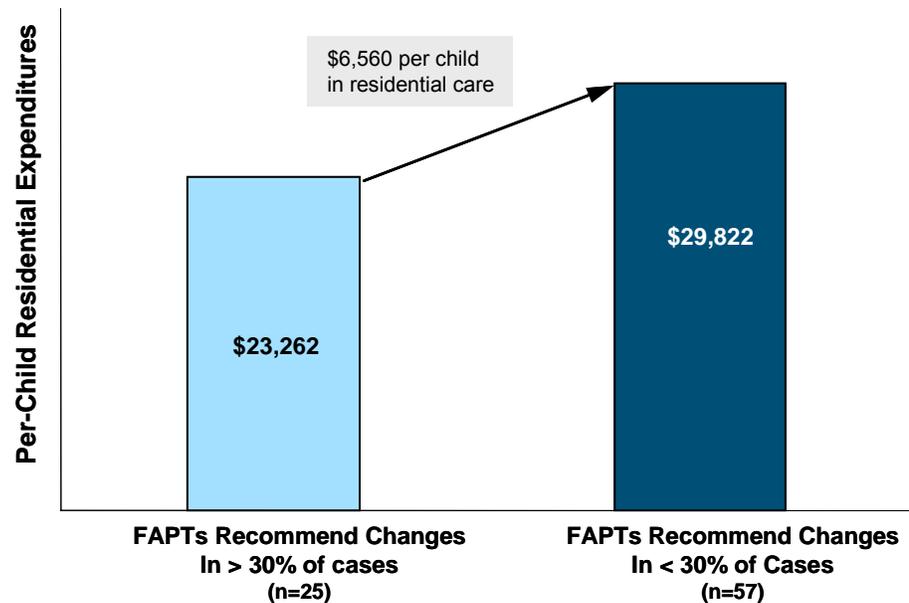
* * *

One local program has aligned each of their FAPTs with different types of service planning needs: children who require residential care, children whose services are determined by an IEP, case managers who are unsure of how best to meet a child's needs, and children who are receiving services in a community-based setting.

JLARC staff analysis indicates that there are some cost containment benefits associated with FAPTs which are able to contribute more frequently to children's service plans. Specifically, local programs whose FAPTs reportedly recommend changes to at least 30 percent of service plans spend approximately \$6,500 less per child for residential care (Figure 48). By prioritizing the cases that the teams review, localities could enable FAPT members to have more meaningful input into children's service plans. This not only maximizes limited staff resources, but may also contribute to lower program costs.

OCS Could Provide Guidance to Localities in Efficient Administration of the FAPT Process. While local flexibility in how to structure the FAPT process should be maintained, all local programs could benefit from OCS guidance on how to structure their FAPT case review to minimize the burden placed on local agency staff resources and maximize the team's contribution to the CSA process. First, OCS may wish to develop SEC-approved guidelines for flexibility granted by the *Code* to use an alternative multidisciplinary case review team. Some localities have already taken advantage of this flexibility, as illustrated by the previous examples. In particular, local programs could be encouraged to better integrate their IEP and FAPT processes. Designating a FAPT member to attend children's IEP meetings could ensure that children's educational as well as non-educational needs are addressed via the IEP process and could eliminate the need for FAPT review of these cases.

Figure 48: When FAPTs Have Greater Input Into Children's Service Plans, Localities Spend Less Per Child in Residential Care (2006)



Note: JLARC staff controlled for the severity of cases, and this did not affect the association between per-child residential cost and the frequency with which FAPTs recommend changes to service plans.

Source: JLARC staff analysis of local CSA program survey responses and OCS FY 2006 client-level expenditure data (first two quarters).

Second, OCS may wish to develop program efficiency guidelines that can be used by local CPMTs to assist them in identifying

- the types of cases their FAPTs add the least value to,
- the types of cases for which FAPT input is essential, and
- whether service plans for some cases could be developed and reviewed by an alternative multidisciplinary process.

As suggested previously, OCS could offer a course on this topic.

Recommendation (28). In order to allow Family Assessment and Planning Teams (FAPTs) to focus on the most complex and potentially costly CSA cases, and thereby maximize their ability to contain program costs, the Office of Comprehensive Services (OCS) should educate local CSA programs statewide about the option of using a multidisciplinary team other than the FAPT for CSA service planning. As part of this effort, OCS should develop guidelines that can be used by all local Community Policy and Management Teams to improve the efficiency and effectiveness of the FAPT process.

Study Mandate

House Joint Resolution No. 60

Directing the Joint Legislative Audit and Review Commission to evaluate the administration of the Comprehensive Services Act. Report.

Agreed to by the House of Delegates, March 2, 2006

Agreed to by the Senate, February 28, 2006

WHEREAS, the Comprehensive Services Act (CSA) was created in 1992 to establish a comprehensive system of services and funding through interagency planning and collaboration in order to better meet the needs of troubled and at-risk youth and their families; and

WHEREAS, concerns associated with the total general fund cost of the program (more than \$194 million in fiscal year 2001) and the average rate at which these costs have been increasing (approximately 10% annually) prompted the 2002 General Assembly to pass budget language directing the Secretary of Health and Human Resources to develop and implement a plan for improving services and containing costs in the treatment and care of children served through the CSA; and

WHEREAS, financial support provided by the Commonwealth and local governments for early intervention services for youth and their families and community services for troubled youth who have emotional or behavior problems continues to increase; and

WHEREAS, these program costs are often unpredictable and have dramatically increased each fiscal year, making fiscal planning and budgeting a difficult process for local governments; and

WHEREAS, the Joint Subcommittee Studying Youth and Single Family Group Homes in the Commonwealth, pursuant to House Joint Resolution No. 685 (2005), has studied the regulation of and zoning and siting issues, services, and reimbursement for children's residential facilities or group homes in the Commonwealth; and

WHEREAS, the Joint Subcommittee has recommended legislation to increase accountability and improve regulatory authority for disciplinary actions in egregious situations; and

WHEREAS, the Joint Subcommittee has received comprehensive data on the regulatory programs for group homes, particularly the interdepartmental regulation of children's facilities through the Departments of Education; Juvenile Justice; Mental Health, Mental Retardation and Substance Abuse Services; and Social Services and the regulation of adult group homes by the Department of Mental Health, Mental Retardation and Substance Abuse Services; and

WHEREAS, although the Joint Subcommittee believes that redundant and duplicative regulatory requirements are unnecessary, the members were disconcerted by the failure of the interdepartmental program to take steps to develop regulations to implement requirements enacted by House Bill No. 2461 and Senate Bill No. 1304 in 2005 and concerned

about the bureaucratic weight caused by requiring four regulatory boards and their departments to "cooperate" in setting and enforcing facility standards; and

WHEREAS, in addition, the Joint Subcommittee received voluminous data on the costs and statistics of placements through the CSA that only served to emphasize the gaps in statewide data on the rates being paid by localities for group home reimbursement of CSA children, the glaring fact that many children are placed out of their home jurisdictions into such group homes, and the apparent lack of monitoring of placements across jurisdictional lines by the responsible parties; and

WHEREAS, the Joint Subcommittee believes that a detailed examination of the rates paid for, efficacy of, and the accountability for Comprehensive Services Act placements must be conducted, as well as an analysis of the interdepartmental regulatory program to determine whether stricter standards, rate setting, and perhaps other measures should be taken to ensure the safety of the vulnerable children placed in group homes; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Legislative Audit and Review Commission be directed to evaluate the administration of the Comprehensive Services Act.

In conducting its study, the Joint Legislative Audit and Review Commission shall:

1. Evaluate the costs, quality, and reimbursement of children's residential services;
2. Examine the interdepartmental regulation of these facilities;
3. Assess the administration of the CSA by state and local governments, including the methodology for projecting caseloads and the costs and adequacy of funding to administer the program at the state and local levels;
4. Ascertain the total costs of CSA residential services for state and local governments and offer recommendations to improve services and contain costs. In conducting this evaluation, the Commission shall examine the current practices of negotiating contracts with residential service providers and identify and assess alternatives that may be more cost effective than current contracting practices, including: (i) analyzing the costs and rates paid, whether the Commonwealth and localities are receiving quality services for the funds expended, and whether group homes and campus facility rates for the placement of CSA children are set rationally and cost effectively; (ii) evaluating effective strategies for negotiating and reporting group homes and residential facilities rates; and (iii) requiring a state agency or instrumentality, such as the Office of Comprehensive Services, to negotiate statewide or regional contracts for residential treatment services funded from the state pool for such services;
5. Consider whether residential facilities that provide "medically necessary" services should be qualified Medicaid providers in order to receive payment from the state CSA funding pool as a means of containing costs;
6. Determine the regulatory and fiscal steps that may be necessary to contain costs, procure quality services, ensure accountability for services, and protect the health, safety, and welfare of children placed in residential facilities, particularly children placed across jurisdictional lines when appropriate services are not available in their communities;

7. Evaluate the quality and capacity of services available to and provided for CSA children and their families;
8. Identify the impact of cross-jurisdictional placements on (i) CSA children without immediate access to their families, communities, and support networks and (ii) local jurisdictions, including but not limited to, services that are not reimbursed through CSA, such as law enforcement, fire protection, mental health services, and education;
9. Determine whether CSA children receive appropriate care, case management, education, supervision, and quality assurance by the funding jurisdiction, whether steps should be taken to increase services in the home jurisdictions of such children, and identify barriers to serving CSA children in their communities;
10. Evaluate the costs and benefits of requiring the local entity responsible for the placement of children across jurisdictional lines, due to a lack of appropriate services and facilities in the home locality, to initiate the development of community-based services, including group homes or other services, to serve the needs of such children and their families and to stimulate the implementation of community-based services; and
11. Assess the regulatory structure and implementation of the Standards for Interdepartmental Regulation of Children's Residential Facilities to determine whether the interdepartmental program should be continued and whether returning the regulatory responsibility for residential facilities to the relevant state agencies would increase accountability and ensure the safety, health, and welfare of the children placed in residential facilities.

Technical assistance shall be provided to the Joint Legislative Audit and Review Commission for this study by the Office of Comprehensive Services, and the Departments of Social Services, Education, Juvenile Justice, and Mental Health, Mental Retardation and Substance Abuse Services. All agencies of the Commonwealth shall provide assistance to the Commission for this study, upon request.

The Joint Legislative Audit and Review Commission shall complete its meetings for the first year by November 30, 2006, and for the second year by November 30, 2007. In each year, the Chairman shall brief the Joint Subcommittee to Study the Cost Effectiveness of the Comprehensive Services for At-Risk Youth and Families Program Senate Joint Resolution No. 96 (2006) no later than November 1, and shall submit to the House Committee on Finance, the House Committee on Appropriations, the Senate Committee on Finance, the Senate Committee on Education and Health, the House Committee on Health, Welfare and Institutions and the Division of Legislative Automated Systems an executive summary of its findings and recommendations no later than the first day of the next Regular Session of the General Assembly. Each executive summary shall state whether the Chairman intends to submit to the General Assembly and the Governor a report of its findings and recommendations for publication as a House or Senate document. The executive summaries and reports shall be submitted as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports and shall be posted on the General Assembly's website.

Research Activities and Methods

Key research activities of this study included

- local CSA site visits;
- surveys of local CSA coordinators, Community Planning and Management Team chairs, case managers of children who received CSA services, and residential service providers;
- quantitative analyses of data collected by the Office of Comprehensive Services (OCS) and the four agencies that license and regulate children's residential facilities;
- case studies of CSA children receiving community-based or residential services and of residential facilities;
- structured interviews; and
- review of child welfare literature.

LOCAL CSA SITE VISITS

JLARC staff visited 17 local CSA programs across Virginia to conduct three structured interviews with (1) the locality's CSA coordinator, (2) individuals who participate in the Community Planning and Management Team (CPMT), and (3) staff from the agencies that participate in the Family Assessment and Planning Team (FAPT), along with case managers. While similar questions were asked in all three interviews, JLARC staff met with each group separately because of their different roles in interpreting and implementing CSA policies. These site visits were conducted between May and August of 2006 and each visit was completed in one to two days. Topics discussed during this visits included

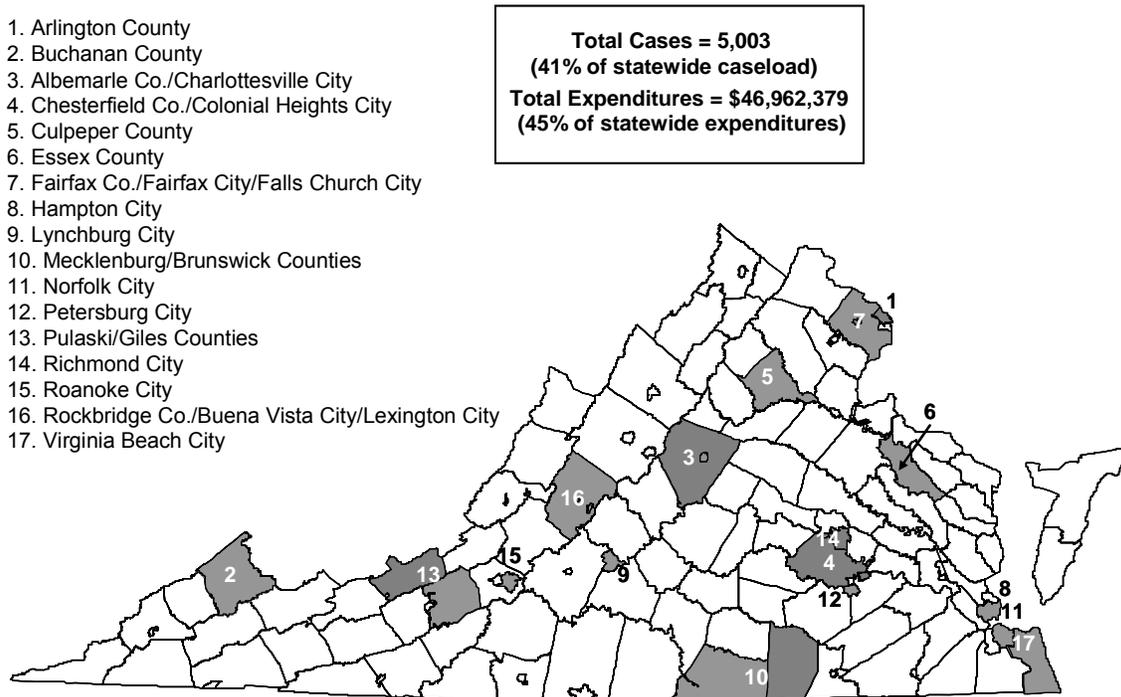
- factors that influence service plans and placement,
- presence of quality control mechanisms,
- child outcomes,
- provider quality,
- service availability,
- rate negotiation,
- cross-jurisdictional placements, and
- potential State actions.

The 17 local CSA programs visited by JLARC staff (Figure 1) were selected based on three criteria:

- (1) size of CSA caseload (small or large),
- (2) proportion of services provided in residential settings during the second quarter of Fiscal Year 2006 (above or below average), and
- (3) average per-child cost (above or below average).

JLARC staff selected 15 local programs with a large caseload and two local programs with a small caseload. Caseload size, proportion of residential placements, and per-child cost were the primary criteria because the study mandate (Appendix A) directs JLARC staff to examine the cost of residential services for at-risk children and its relationship to the increase in overall program expenditures. These three variables are the primary contributors to a locality's costs and its proportion of statewide expenditures.

Figure 1: Locations of 17 CSA Programs Visited by JLARC Staff



Note: Some localities have combined to create one local CSA program.

Source: JLARC staff analysis of FY 2006 (first & second quarter) CSA program data from the Office of Comprehensive Services.

SURVEYS

JLARC staff conducted surveys of four different groups of CSA stakeholders: (1) CSA coordinators, (2) CPMT chairs, (3) case managers of children receiving CSA services, and (4) providers of children's residential services. These surveys allowed JLARC staff to build a more comprehensive understanding of the study issues than was permitted through structured interviews of local CSA stakeholders or quantitative analysis of CSA program and other related data.

Survey of CSA Coordinators

JLARC staff surveyed local CSA coordinators in all localities across the State. Coordinators were asked to summarize approaches to local program administration, identify factors that influence their ability to develop the most appropriate and cost-effective services for CSA children, and specify the most common reasons for increasing program expenditures. Although the topics addressed in this survey were similar to those covered during site visits, results from this statewide survey enabled JLARC staff to better understand the extent of local variation in CSA program administration, service planning, and other factors that influence program expenditures and children's outcomes.

Eighty-one percent of CSA coordinators responded to the survey. Using these survey responses, JLARC staff analyzed relationships between certain survey variables and CSA program variables from the child-level database maintained by the Office of Comprehensive Services (OCS). The results of these analyses are discussed in more detail in Chapters 5 and 7.

JLARC staff also requested information about cross-jurisdictional placements separately from the main survey. While the child-level database maintained by OCS includes a wealth of information about the nature and cost of services received by CSA participants, it does not contain information about the specific facility where a child might have received residential care. Consequently, this dataset could not be used to identify which children are placed in facilities outside of their jurisdiction. Therefore, the JLARC staff surveyed all local CSA coordinators to determine how frequently cross-jurisdictional placements occur and which localities are most affected. This information was used to determine how many children localities send out of their jurisdiction and take into their locality, and which localities experience a significant net influx of children placed within their local boundaries.

Survey of CPMT Chairpersons

JLARC staff asked all local CPMT chairpersons to complete a service gaps assessment for their locality in order to identify which gaps have the largest negative impact on their ability to help children in their homes, schools, and communities. This assessment also allowed JLARC staff to identify why services are lacking and which strategies could be used to help address these gaps. Seventy-two percent of CPMT chairs responded to this survey.

Survey of CSA Case Managers

To collect information on the extent to which CSA participants improve over time, JLARC staff conducted a survey of children's case managers. Information gathered through this survey provided a more complete understanding of children's outcomes after receiving residential services. Specifically, JLARC staff asked case managers about children's behaviors in their homes, schools, and communities, which served as outcome measures. Case managers were also asked whether they had seen overall improvements in the children since receiving residential services and were satisfied with the services received.

JLARC staff used the OCS database to draw a sample of CSA children who had ended residential services in the second half of 2005. There were 117 responses from case managers constituting a response rate of 49 percent.

Survey of Residential Providers

JLARC staff also administered a survey of 184 residential facilities that serve CSA participants. This survey was divided into six sections that reflect the different provider-related issues examined for this study: (1) background information and program staffing, (2) staff qualifications, (3) rates, (4) financial information, (5) child outcomes, and (6) referrals and discharges.

The survey sample of 184 residential facilities excludes DJJ facilities that do not serve CSA children. In addition, if a provider operated more than one facility, a sample of one to three facilities was chosen based on facility characteristics to minimize the effort of any one provider and increase the likelihood of receiving responses. Of the 184 residential facilities surveyed, 27 were removed from the survey sample because they do not receive CSA funding and five are no longer in operation. Eighty-six percent of the remainder responded, and 22 did not participate in the JLARC survey (Table 1 includes a profile of the non-responding facilities). It appears that the facilities that did not respond to the survey exhibit slightly different characteristics than respondents as a whole.

The majority of the 22 children’s residential facilities that did not respond to the JLARC staff residential provider survey have the following characteristics (Table 2):

- more likely to be licensed by DMHMRSAS and less likely to be licensed by the Department of Social Services (DSS),
- more likely to be smaller,
- more likely to be a newer program,
- less likely to hold a triennial license and more likely to have an annual license, and
- more likely to be for-profit.

Table 1: Profile of Non-Respondents to JLARC Residential Provider Survey

Facility Name	Locality	Lead Agency	Capacity	Years of Operation	License Type	Tax Status
180 (degrees) Boys Adolescent Group Home	Chesterfield	DSS	8	2	Triennial	For Profit
Agape Unlimited, Inc.	Petersburg	DMHMRSAS	8	8	Triennial	For Profit
Brookfield	Henrico	DSS	20	30	Triennial	Nonprofit
Centerville Group Home	Chesapeake	DJJ	13	27	Triennial	Nonprofit
Community Solutions	Norfolk	DSS	7	1	Annual	For Profit
Delta House	Henrico	DSS	8	2	Annual	For Profit
Family Solutions, Inc.	Portsmouth	DMHMRSAS	8	2	Triennial	For Profit
Flossie’s Place	Henrico	DSS	8	2	Annual	For Profit
James Bentley Treatment Program	Portsmouth	DMHMRSAS	4	1	Annual	For Profit
Less Secure Detention Home	Hampton	DJJ	20	29	Triennial	Nonprofit
Little Keswick School	Albemarle	DOE	31	28	Triennial	For Profit
Loudoun Youth Shelter	Loudoun	DJJ	12	7	Triennial	NA
P.O.P.’s House	Henrico	DSS	8	3	Triennial	NA
Paramount House	Norfolk	DMHMRSAS	8	7	Triennial	For Profit
Poplar Place of Sutherland	Dinwiddie	DMHMRSAS	8	2	Annual	Nonprofit
Poplar Springs Hospital	Petersburg	DMHMRSAS	108	2	Annual	Nonprofit
Renewance Services	Petersburg	DMHMRSAS	4	3	Triennial	For Profit
Rion’s Hope	Richmond (city)	DMHMRSAS	6	2	Annual	For Profit
Safehaven	Newport News	DSS	12	14	Triennial	Nonprofit
Sebastien House	Portsmouth	DMHMRSAS	7	4	Annual	NA
Vanguard Adolescent Program	Arlington	DMHMRSAS	12	<1	Annual	Nonprofit
Youth Pathway	Chesterfield	DMHMRSAS	11	4	Annual	For Profit

Source: JLARC staff analysis of licensing data from the Office of Interdepartmental Regulation and Department of Mental Health, Mental Retardation & Substance Abuse Services and information from the Office of Comprehensive Services Service Fee Directory.

Table 2: Comparison of Characteristics of Non-Respondents and Respondents to JLARC Residential Provider Survey

		Non-Respondents (N = 22)	Respondents (N = 130)
Lead Agency	DSS	32%	45%
	DMHMRSAS	50%	41%
	DOE	5%	5%
	DJJ	14%	7%
Capacity	12 or less	77%	65%
	13 or more	23%	35%
Years of Operation	2 or less	45%	31%
	3-5	18%	12%
	6 or more	36%	57%
License Type	Triennial	55%	72%
	Annual	45%	20%
	Conditional	0%	6%
	Provisional	0%	2%
	Other	0%	1%
Tax Status	For Profit	55%	45%
	Nonprofit	32%	51%
	Unavailable	14%	5%

Source: JLARC staff analysis of licensing data from the Office of Interdepartmental Regulation and JLARC Provider Survey results.

QUANTITATIVE ANALYSIS OF CSA PROGRAM AND OTHER DATA

JLARC staff conducted numerous quantitative analyses of CSA program data, as well as other data received through surveys of residential providers and from licensing agencies. JLARC staff developed specific decision rules to determine which children or residential facilities to include in the analyses. Subsequently, several variables were created to further analyze the CSA program, survey response, or licensing data.

Analysis of CSA Program Data

The Office of Comprehensive Services (OCS) maintains a dataset containing information about the services and expenditures associated with all children who have received CSA services since July 2003. The dataset also includes for each child basic demographic characteristics, reasons for needing services, standardized assessment scores, and referral sources. Since the dataset includes multiple records for each child who has received more than one service through CSA, JLARC staff created an unduplicated dataset so that each child's information was contained longitudinally in one record. In addition, JLARC staff excluded from the analysis services

received and expenditures incurred between July 2003 and June 2004 because of concerns OCS staff expressed about the accuracy and completeness of the data reported during the first year in which data were collected.

Analysis of CSA Children's CAFAS Scores. JLARC staff used scores from the Child and Adolescent Functional Assessment Scale (CAFAS), a standardized assessment tool, which are reported in the CSA child-level database to measure children's outcomes after receiving CSA services. The CAFAS is administered every quarter on all children receiving CSA services, and their scores (eight subscales and a total) are entered into the CSA database. JLARC staff compared children's scores from their first CAFAS assessment with their most recent score for those children who had received at least one residential service. For some children, the most recent score was their last score prior to exiting the program.

Analysis of Services Received By CSA Children. In addition to the CAFAS analysis described above, JLARC staff analyzed the changes in services received over time as another measure of child outcomes. JLARC staff then created the following four service categories, in order of restrictiveness:

- (1) community-based services,
- (2) group home care,
- (3) residential treatment services, and
- (4) psychiatric hospitalization.

After creating these service categories, JLARC staff selected the most restrictive service received for each child during their first and last month in CSA, or if still in CSA as of March 2006. These variables were used to calculate the following:

- proportion of children who were receiving residential services during their first month in CSA,
- proportion of children who "stepped up" to a more restrictive residential service,
- proportion of children who "stepped down" to a less restrictive residential service, and
- proportion of children who were receiving services in the same type of residential setting.

Financial Analysis of CSA Service Expenditures. CSA program expenditures were calculated by merging together child-level information maintained in the CSA dataset and Medicaid claims data supplied by the Department of Medical Assistance Services (DMAS) for services rendered between July 1, 2004 and March 31, 2006. DMAS claims data reflected CSA services covered by Medi-

caid through the State's plan, which include residential care provided in Medicaid-certified residential facilities and intensive case management provided to children living with treatment foster care families. Using this aggregated dataset, JLARC staff calculated the following components of program spending:

- number of children served using pool or Medicaid funding,
- subset of children who received residential services,
- type of residential setting where children were served,
- total number of days spent in residential facilities,
- amount paid to residential facilities per day, and
- funding stream used to pay for residential services.

These figures were calculated over two comparable periods of time: (1) July 1, 2004, to March 31, 2005, and (2) July 1, 2005, to March 31, 2006. An analysis was then conducted to identify to what extent each component of program spending contributed to the rise in residential expenditures. In addition, a sensitivity analysis was performed to identify the magnitude by which each of the components would need to change in order to save \$1 million in Virginia spending.

Analysis of Residential Provider Survey Data

JLARC staff used the results of the provider survey to identify the scope of services provided by Virginia's residential providers, the rates charged for these services, and their profitability. In addition, residential providers' information about the number, experience, and education of their staff was used to determine where Virginia providers stand in comparison with national requirements outlined by Virginia and the Child Welfare League of America (CWLA) standards.

Facilities' Rates and Financial Information Were Analyzed. JLARC staff analyzed the financial information contained in the 2004 and 2005 income statements reported by residential providers to first determine the factors associated with rate increases. An analysis was conducted to identify whether facilities that increased rates shared certain financial characteristics, such as having sustained a loss in the previous fiscal year, or experiencing significant increases in program expenditures. In addition, JLARC staff calculated the magnitude and distribution of profit margins realized by children's facilities. Margins were calculated by subtracting total program expenses and taxes from total revenues received by residential facilities, including both fees and other revenue sources such as investment income. Profit margins were then calculated by

dividing the amount of revenues in excess of expenses by total revenues.

In addition, staffing levels, personnel qualifications, and other program characteristics such as tax status were used to assess the extent to which variation in facilities' daily rates is associated with differences in programs. A correlation analysis was conducted to assess the extent of the association between rates and various program characteristics. Using the factors most strongly correlated with rates, various regression models were constructed to maximize the amount of rate variation that could be explained by program characteristics.

Providers selected the facility type that best reflected their programs. In cases where this information was not supplied, a facility type was assigned based on the size of the facility: facilities with a capacity of 12 or fewer residents were categorized as "group homes," and other facilities were designated as "residential treatment facilities."

Facilities' Staff Qualifications Were Compared to Those Required by Standards. Because staff ratios prescribed by CWLA standards vary by facility type, JLARC staff assigned a facility type to each provider based on the data collected through the survey. The facility's staffing ratio was then compared to CWLA's required ratio for that facility type to determine whether the facility met the requirement.

In addition, CWLA standards outline various staff qualification requirements, which typically include education and experience levels for various positions. Survey questions were designed to elicit information that could be used to determine how many staff in each position met the two sets of requirements. For example, survey questions asked each provider how many direct care staff have a high school degree, bachelor's, master's, or PhD. This question was repeated for each position. Based on how the information was collected, JLARC staff could not identify how many individual staff in each facility met both the education and experience requirements, but were able to calculate the overall proportion of staff for each facility that met either one requirement or the other.

Analysis of Licensing Data

JLARC staff obtained licensing data from the Office of Interdepartmental Regulation (OIR), the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS), and the Department of Juvenile Justice (DJJ). OIR provided a licensing history of all licensed children's residential facilities between April 1, 2001, and March 31, 2006, including

- license type and corresponding effective dates,
- facility capacity, and
- open and close dates.

OIR also provided data on types of licensing inspections and corresponding dates, violated standards and corresponding dates cited, and complaint information for facilities where DSS or DOE was the lead licensing agency. DMHMRSAS provided similar data on the facilities for which it was lead agency for the period between January 1, 2003, and March 31, 2006. In addition, DJJ provided information on the two most recent inspections and all complaint investigations between April 1, 2005, and March 31, 2006, for facilities where it was lead agency.

Because the licensing data contained multiple records per facility, JLARC staff created an unduplicated dataset that contained one longitudinal record for each facility. This involved computing the total number of violations, inspections, and complaints for each facility.

Juvenile detention facilities licensed by DJJ were excluded from this analysis because these facilities do not receive CSA funding and typically do not serve CSA participants. Additional facilities were excluded if they contacted JLARC staff upon receiving the provider survey and indicated that they do not serve CSA children.

Some of the primary analyses conducted using this licensing data include the following:

- average number of violations each facility incurred in their first four years of operation,
- number of inspections missed per year for each lead agency,
- average number of violations and critical violations (as identified by licensing specialists) based on total number of inspections,
- average number of violations and critical violations by type of facility (based on licensing data and data collected through the survey),
- average number of days between licensing inspections,
- number of facilities with repeated violations, and
- number of repeated violations for each facility.

CASE STUDIES

Two types of case studies were examined by JLARC staff for this study. First, JLARC staff requested case studies from local CSA coordinators in order to better understand the complexity of the problems presented by children served through the CSA program and the circumstances that resulted in their need for services. These case studies also provided insight into the level of need demonstrated by CSA children, and the strategies used to help them overcome emotional and behavioral problems.

Second, JLARC staff received case studies of residential facilities from licensing agencies, which allowed JLARC staff to illustrate the consequences of facilities having inadequate staffing levels, a lack of staff training requirements, and minimum staff qualifications. Additional case studies were identified through licensing data or negative action letters provided by licensing staff.

STRUCTURED INTERVIEWS

JLARC staff conducted several interviews with staff of the following entities to gain additional insight into the structure and intent of the CSA program, types of problems experienced by CSA children, local placement decisions of children receiving CSA services, availability of services, quality and effectiveness of services, cost of services, and the licensing process of residential facilities:

- Office of Comprehensive Services,
- State Executive Council,
- State and Local Advisory Team,
- Virginia Coalition of Private Providers Association,
- Virginia Association of Community Services Boards,
- Office of Interdepartmental Regulation,
- Virginia Department of Social Services,
- Virginia Department of Education,
- Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services, and
- Virginia Department of Juvenile Justice.

Additional interviews were conducted with several residential facilities to further understand the characteristics of their residents, types of programs and services provided to CSA children, staff background and qualifications, effectiveness of the interdepartmental regulations, how local placement decisions are made, the rate determination process, and whether the facilities track out-

come measures of their children. Furthermore, JLARC staff accompanied licensing specialists during several site inspections to observe the regulatory process.

REVIEW OF LITERATURE, REGULATIONS, AND POLICIES

JLARC staff reviewed numerous documents and studies to supplement and validate findings, as well as to identify other states' best practices that could be transferred to Virginia. First, numerous prior studies of the CSA program were reviewed to establish what was already known about CSA children, the types of services they receive, and what changes have taken place since the inception of the CSA program. In addition, results from studies in other states were consulted. Moreover, JLARC staff examined Virginia's licensing standards and regulations for children's residential facilities, as well as standards developed by the Child Welfare League of America. Finally, JLARC staff reviewed federal and State statutes and policies related to the CSA program.

Acronyms

ALF	<u>Assisted Living Facility</u> – Non-medical residential settings that provide or coordinate personal and health care services, 24 hour supervision, and assistance for the care of four or more adults who are aged, infirm, or disabled.
APA	<u>Administrative Process Act</u> – Provides the basic framework for rulemaking in Virginia. The APA sets out the stages of the regulatory process, including notice and comment; requires agencies to promulgate public participation guidelines on how the public can be involved in the rulemaking process; and requires the Governor to publish procedures for executive review of regulations.
CAFAS	<u>Child and Adolescent Functional Assessment Scale</u> – A standardized assessment tool that assesses a youth’s degree of impairment in day-to-day functioning due to emotional, behavioral, psychological, psychiatric, or substance use problems.
CAO	<u>Chief Administrative Officer</u> – An executive director of a business or program.
CPMT	<u>Community Policy and Management Team</u> – Top tier management responsible for policy development and fiscal management of CSA program at the local level. Mandatory membership includes the local agency heads or their designees from the Community Service Boards, local departments of social services, Health Department, Juvenile Court Services Unit, and school division; a parent representative; a private provider representative; and at least one elected official or appointed official, or his designee.
CRF	<u>Children's Residential Facility</u> – Residential setting that provides 24-hour care, guidance, and protection to children. Facility types include group homes, residential treatment facilities, emergency shelters, inpatient psychiatric treatment facilities, wilderness programs, and diagnostic programs.
CSA	<u>Comprehensive Services Act</u> – A Virginia law that provided for the pooling of eight specific funding streams used to purchase services for high-risk youth. The purpose of the act is to provide high quality, child centered, family focused, cost effective, community-based services to high-risk youth and their families.
CSBs	<u>Community Services Boards</u> – Non-profit organizations that offer individuals across Virginia comprehensive mental health, mental retardation, and substance abuse services. Individuals are often referred to CSBs for in-depth assessment or treatment.
CWLA	<u>Child Welfare League of America</u> – CWLA is a national association of nearly 800 public and private nonprofit agencies that advocates for the welfare of children.

- DJJ** Department of Juvenile Justice – The State agency that provides supervision and management support to 35 court services units that administer juvenile justice services throughout Virginia.
- DMAS** Department of Medical Assistance Services – One of 11 agencies within Virginia’s Health and Human Resources Secretariat, DMAS is responsible for administering the Medicaid and Family Access to Medical Insurance Security (FAMIS) programs. DMAS integrates and coordinates these programs with other State and federal programs that provide health care financial assistance and ensures that health care services are available when medically necessary.
- DMHMRSAS** Department of Mental Health, Mental Retardation and Substance Abuse Services– The State agency that provides supervision and management support to 40 community services boards, which administer the majority of mental health, mental retardation, and substances abuse services available in Virginia.
- DOE** Department of Education – The State agency that provides supervision and management support to the 136 public school divisions throughout the State.
- DSS** Department of Social Services – The State agency that provides supervision and management support to 120 local departments of social services, which administer the vast majority of the 50 social service programs available in Virginia.
- FAPT** Family Assessment and Planning Team – Second tier management of local level CSA programs that is responsible for reviewing and assessing children and families referred for services, and developing individualized family service plans and providing recommendations for funding. Mandatory membership includes representatives from the community services boards, local departments of social services, Juvenile Court Service Unit, school division, a parent representative and a Health Department representative at the request of the chair of the CPMT.
- FTE** Full-Time Equivalent – A full-time equivalent position, or full-time worker.
- IEP** Individualized Education Plan – Addresses the special education and related service needs of eligible children. The IEP is developed by the local school division.
- NARA** National Association for Regulatory Administration – Represents all human care licensing, including child care, child welfare, adult day care, adult residential and assisted living care, and program licensing for services related to mental illness, developmental disabilities and abuse of drugs and alcohol.
- OCS** Office of Comprehensive Services – Serves as the State-level administrative entity for the Comprehensive Services Act. OCS is responsible for providing training and technical assistance to local CSA programs, advising the State Executive Council on program and fiscal policies, collecting expenditure and service data from localities, and maintaining a database of authorized providers of CSA services.

- OIR** Office of Interdepartmental Regulations – This office coordinates the children's residential regulatory activities conducted by the lead licensing agencies. OIR facilitates the development of regulations and conducts training for regulatory personnel and facility providers on a variety of topics. OIR also processes background checks for facilities licensed by the four lead agencies.
- SEC** State Executive Council – Acts as the supervisory board of the Comprehensive Services Act. Membership is comprised of the Commissioners of the Department of Health, the Department of Social Services, the Department of Mental Health, Mental Retardation and Substance Abuse Services, Chairman of the state and local advisory team, Superintendent of Public Instruction, Director of the Department of Juvenile Justice, Executive Secretary of the Supreme Court, and Director of the Department of Medical Assistance Services. Also to be included on the SEC are a representative from the county board of supervisors or city council, a county administrator or city manager, private provider, and a parent representative.
- SFD** Service Fee Directory – Internet resource that provides information regarding the availability of children services and fees for those services. Private and public providers submit information to the SFD describing their programs, locations and maximum fees.
- SLAT** State and Local Advisory Team – Serves as an advisory body to the State Executive Council. The SLAT acts as a collaborative forum for the various State and local CSA stakeholders to regularly discuss the program's administration and advise the State Executive Council on any issues that might arise.
- TFC** Therapeutic Foster Care – TFC families receive additional payments for daily supervision for children who have emotional/behavioral, developmental, physical, or medical disorders. TFC parents must meet additional training requirements. Private child-placing agencies manage the majority of TFC services in Virginia and are responsible for TFC training and support.
- UM/UR** Utilization Management and Utilization Review – Utilization management is a set of techniques used by or on behalf of purchasers of health and human services to manage the provision and cost of services by influencing client care and decision making through systematic data driven processes. Utilization review is a formal assessment of the necessity, efficiency, and appropriateness of the services and treatment plan for an individual. Utilization review is part of the utilization management process.

Agency Responses

As a part of the extensive validation process, State agencies and other entities involved in a JLARC assessment effort are given the opportunity to comment on an exposure draft of the report. Appropriate technical corrections resulting from comments provided by these entities have been made in this version of the report. This appendix includes written responses from the Secretary of Health and Human Resources, Office of Comprehensive Services, and the Department of Education.



COMMONWEALTH of VIRGINIA

Office of the Governor

Marilyn B. Tavenner
Secretary of Health and Human Resources

December 5, 2006

Philip A. Leone
Director
Joint Legislative Audit and Review Commission
General Assembly Building, Suite 1100
Richmond, VA 23219

Dear Phil,

Thank you for the opportunity to review and respond to the exposure draft "Evaluation of Children's Residential Services Delivered through the Comprehensive Services Act." Let me begin by expressing my appreciation to you and the members of the JLARC staff for your work on this project and for meeting with us to review this draft in some detail. The Comprehensive Services Act -- both from a diverse population of children served as well as from a funding perspective -- is certainly one of the more complicated systems within Virginia government.

Since the inception of CSA in 1992, when Virginia led the nation as an innovator for coordinated services for at-risk children, we've continued to strive for further improvements in this program. As a whole, your recommendations offer the Governor and General Assembly many additional ideas for advancing the quality and quantity of care for some of our most vulnerable children and their families.

Accountability for program outcomes is a priority of the Kaine Administration. Your recommendation to strengthen coordination of services and to measure the outcomes of children receiving such services is commendable. Your recommendation is in line with the strategic planning process within this Administration and the State Executive Council. Where we fall short of our goals, you can be assured we will strive to improve.

I urge caution in a few parts of your report. The CSA system embodies public-private partnerships in service delivery. We must ensure that our regulatory environment protects children -- that is our foremost goal. We must also ensure that proposed regulatory solutions are appropriate and actually accomplish our goals.

Philip A. Leone
December 5, 2006
Page 2 of 2

In Chapter 2, you discuss other states with staffing standards higher than Virginia. Unless you can clearly demonstrate that increased staffing can be directly linked to improved outcomes for children, we should tread carefully here. Required investment in additional staff, without the evidence to suggest better treatment outcomes, would impede other recommendations you offer for cost containment.

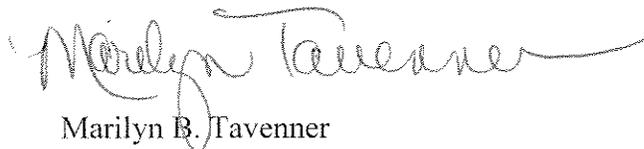
Before you conclude that staffing or any other baseline standards are inadequate, we must ensure that our current standards are enforced. Your report identifies a number of enforcement shortcomings, and those must and will be addressed. Adequate numbers and training of licensing staff are a start.

We must also recognize the staffing challenges faced by our private partners. Chapter 2 refers to the lack of training and education of the workforce in children's residential facilities. I concur with the need for additional training. Yet, many of these facilities have annual staff turnover rates in excess of 50%. This issue is not limited to children's residential facilities -- it is symptomatic of a national healthcare workforce shortage. This Administration intends to address workforce shortages throughout Virginia's healthcare industry. Demand for and retention of well-trained staff will continue to grow, as we continue to experience success in community placements of individuals with mental or physical needs.

Local governments are also an integral partner of our CSA system. Over the years, we have attempted to help them in selecting the highest quality providers at reasonable costs. Yes, there is more we can do in this regard. Your finding in Chapter 5 that "some providers may charge high rates and realize excessive profit margins" refers to a relatively small subset of providers statewide. Others have experienced smaller profits, and still others, losses.

In closing, let me say that I look forward to working with you and members of the General Assembly to make our CSA system a model for the nation. I am committed to implementing any recommendation that will improve the quality of life for our children and better help our local and private partners in providing those services.

Sincerely,



Marilyn B. Tavenner

MBT/aac

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COMMONWEALTH of VIRGINIA

COMPREHENSIVE SERVICES ACT FOR AT-RISK YOUTH AND FAMILIES

December 5, 2006

Mr. Philip A. Leone, Director
Joint Legislative Audit and Review Commission
General Assembly Building
Richmond, VA 23219

Dear Mr. Leone:

The Office of Comprehensive Services (*OCS*) appreciates this opportunity to comment on the draft Joint Legislative Audit and Review Commission (*JLARC*) report, "Evaluation of Children's Residential Services Delivered Through the Comprehensive Services Act." Our comments address the areas of the report that are not related to the regulation of children's residential facilities.

I commend JLARC staff for their professional and comprehensive review of CSA. They quickly learned the complexities and interconnections of this program. They focused on the areas that would improve services for children and families and contain costs for state and local governments.

The JLARC report focused primarily on the current CSA system and residential services. It did not provide the historical context and recent improvements in the CSA program by the Warner and Kaine Administrations and the General Assembly. Therefore, this letter provides: the historical context on residential care expenditures; major improvements in the CSA program over the past four years; and OCS' comments endorsing JLARC's recommendations.

Historical Context on Residential Care Expenditures. Prior to CSA, expenditures for purchasing residential services were increasing at a rate of 22% annually in three separate programs across three Secretariats – foster care, special education, and juvenile justice. (*Department of Planning and Budget's Study of Children's Residential Services, 1990*). JLARC confirmed that program costs increased at a rate of 22% annually from FYs 1989-1993, except for a one year drop from FYs 1991-1992 (*JLARC Report, 1998*).

The complex funding structure for residential care included 14 funding streams in four agencies, each with a different match rate. What initially appeared to be 14,000 children across the four agencies were in fact less than 5,000 children. More than 80% of these children were served by two or more child serving agencies. While more than one third of the children were served by at least three agencies, the agencies were often not aware they were serving the same child (*DPB Study, 1990*).

Localities reported that service decisions were often driven inadvertently by bureaucratic requirements of funding streams, rather than the needs of children and families. Some funds were managed and service decisions made at the state level, which was not effective because the state did not know the children nor community resources available (*DPB Study, 1990*).

CSA legislation in 1992 dramatically restructured funding and services for children with emotional and behavior problems and their families. It was designed to strengthen collaboration and pooling of resources across systems for children and families involved with multiple agencies, while each agency retained responsibility for providing services within their normal scope of duties. It simplified the funding structure by pooling eight categorical funds across the four child serving agencies into one CSA state funds pool. The funds were allocated to community teams that knew best their children and resources. Authority and accountability were placed at the local level.

Restructuring the funding increased the visibility of these children, services and costs for state and local governments. When funding streams were housed in large budgets of multiple agencies, the 22% annual increase and costs for purchasing residential care were not visible.

CSA has been successful in increasing collaboration across systems to serve children and families, while controlling the rate of growth in CSA expenditures. Since the implementation of CSA, the rate of increase in CSA state pool expenditures declined. During the first three years of CSA implementation, state and local expenditure growth averaged 17.4% annually (*from 1994 to 1996*). During the next 4 years, the average annual rate of increase declined to 11.2% (*1997 through 2000*). Since 2000, the average annual rate of increase for CSA expenditures (*state, local and Medicaid*) was 9.5% with the introduction of Medicaid and federal Title IV-E funds for CSA children.

Major improvements in the CSA program. The Secretary's Office of Health and Human Resources, the General Assembly, and the State Executive Council made significant improvements in CSA over the past four years.

Instituting results accountability

- Governor Kaine directed OCS to establish performance measures for CSA in 2006.
 - As a baseline in 2005, 38.44% of children who received services through the CSA funds pool were provided services in their homes, school and community (*CSA Data Set*).
 - The Governor established a target for OCS of 50% of children by 2009.
- The SEC approved a results accountability framework for CSA in June 2006 that is consistent with the work of the Council on Virginia's Future.
- SLAT and representatives from CSA stakeholder groups have identified areas for CSA performance measures. SLAT is now analyzing which measures are most effective and feasible, relying on current data when possible.

Strengthening leadership through major structural changes at the state level in 2003 and 2005

- ***CSA State Executive Council***
 - The Cabinet Secretary of Health and Human Resources, or a designated deputy, was required by statute to serve as chair ensuring top Administration leadership.
 - Two legislators were appointed by statute (*one member from the House of Delegates; one member from the Senate*) to provide strong legislative involvement.
 - The Secretary required agency heads or their chief deputy to attend SEC meetings.
- ***State and Local Advisory Team (SLAT)***
 - A local government representative was required by statute to chair to ensure local leadership.
 - Three task groups were established in September 2005 to implement CSA priorities.
- ***OCS***
 - An Executive Director was hired in January 2005 to help take CSA to the next level.
 - OCS' organizational structure was aligned with its mission and priorities during 2005.

Maximizing alternative funds to reduce rate of CSA expenditure growth

- The Virginia Department of Social Services (*DSS*) worked to enable localities to claim certain expenditures allowed under Title IV-E.
- DSS convened a stakeholder group that unbundled some IV-E services.
- State and local governments began maximizing the use of Medicaid and Title IV-E funds to support CSA services.
- OCS began posting grant announcements on its website to inform localities of alternative funding sources from federal, state and non-profit agencies.

Expanding access to community services and reducing residential care for children who can be effectively served in the community

- The SEC identified that 25% of CSA children were placed in residential care at some point during 2005, representing almost half (47%) of all CSA expenditures (*December 2005 Biennial Report*). While residential care is an important part of a continuum of care, it noted that many localities reported that children were placed in more restrictive, out-of-community care than necessary, resulting in higher costs. It identified that communities needed:
 - Community services to prevent placements of children in more restrictive settings outside of their communities than necessary.
 - Providers willing to develop wraparound services tailored to meet the needs of difficult children and their families.
 - Start-up funds for developing services in family, schools, and community settings.
 - Pooling funds across communities to provide economies of scale to develop services.
 - Expertise in conducting assessments, developing creative service plans, and providing care coordination for children and families to effectively serve them in the community.
 - Clinical expertise to assess the necessity, appropriateness and effectiveness of continued placement in residential care and to assist with discharge planning to reduce length of stay.
- SLAT and DMHMRSAS' Child and Family Behavioral Health Policy and Planning Committee (*330-F*) established a joint subcommittee to expand community services.
- CSA implemented a new Innovative Community Services Grant Program with funds by the General Assembly to provide start up funds to spark development of community services targeted to reduce unnecessary residential placements.
- OCS distributed information to all CPMTs and CSA Coordinators on children and expenditures in their community in residential care for program years 2005 and 2006.
- OCS assumed responsibility for utilization management of residential placements for 46 communities that do not have staff to perform this function (*July 2006*). OCS provides clinical consultation to assist communities in making appropriate and cost-effective care decisions.

Building capacity of communities to improve CSA

- OCS Technical Assistance Coordinators were assigned to geographic regions. In 2005, they:
 - Provided technical assistance to 96% of communities (*126 of 131*)
 - Made 75 onsite visits to 60 of 131 communities (*46%*).
 - Facilitated and/or participated in 46 community/regional meetings with members from the CPMT, FAPT, local government, and agencies.
- Technical assistance tools were developed: model utilization management plan; standard provider contract; model individual family services plan; community CSA self-assessment tool; resource sheets on child and family assessments, creative service planning, discharge planning.
- Trainings were implemented on Medicaid/FAMIS, Title IV-E and CSA topics.

Improving management information

- A new CSA data set was implemented on July 1, 2003, providing demographic, service, expenditure and some outcome information by child for all children receiving services through the CSA state funds pool. Accurate expenditure data by child for all CSA services was implemented for FY 2005. All CSA financial reporting information is now communicated using a web based application, eliminating papers and forms.
- Access to the statewide CSA data set information was provided to localities, allowing them to prepare analyses to meet the needs of local governments. Customized data analyses were provided to assist individual communities with utilization management.
- On-line reports are being finalized for all localities to easily access management information to enhance local decision-making.
- The CSA service fee directory was updated to provide access to licensing information and discrete service and rate information.

OCS Comments on JLARC Recommendations

We fully support JLARC's recommendations as important strategies to significantly improve care for children and families. The recommendations that impact the CSA system cover five critical areas that the SEC, SLAT, seven task groups, and this Office have been working on extensively this year.

Measuring child and family outcomes. JLARC's recommendations support the work of the State Executive Council and CSA stakeholders on performance measures:

- ***Mandatory Standardized Assessment Tool.*** Given concerns on the value and cost of the current tool, a SLAT Task Group has evaluated 20 assessment instruments and will recommend whether to continue using CAFAS or adopt a different tool. It is also developing strategies to ensure the tool is used to its fullest capacity, including providing ongoing training. If a new tool is recommended, SLAT will determine what changes would be required to the information systems and the costs for making these changes at the state and local levels. A decision will then be made on the assessment tool (*Recommendation #10*).
- ***Adding fields to the CSA data set to better measure child outcomes.*** OCS fully supports adding fields to capture information on reasons services ended, a residential care provider number, and child outcomes. This will require changes to the information systems at both the state and local levels and it will also require additional work for staff in localities to enter this information. Therefore, we want to emphasize the importance of JLARC's recommendation to assess the financial and staffing resources necessary for implementation at both the local and state levels. This analysis should incorporate the resources required if a new standardized assessment tool is recommended (*Recommendations #11 and #14*).

Capturing total expenditures for more informed decision-making. We fully concur with JLARC staff that more complete service and expenditure information is needed to allow more informed decision-making at the state and local levels for the children funded through the CSA funds pool (*Recommendation #15*). An important issue to resolve is on which children, services and funding streams do state and local governments need more complete information for decision making. (*Recommendation #16*).

Once the appropriate population is determined, we will work collaboratively with other state agencies and communities to conduct a cost-benefit analysis (*Recommendation #17*). This analysis will determine whether this information should be reported by localities through the CSA data set or whether the data sets across DMAS, DSS and other agencies should be merged at the state level.

Given the significant administrative demands on localities for CSA and the minimal state funding provided for local administration, it may be more practical for the state to merge this information annually at year end. While this would be labor intensive and not as accurate, it would provide more service and financial information for decision-makers than is currently available.

Expanding community services. We fully concur with JLARC's recommendations to expand community services to provide children access to services that most appropriately and effectively meet their needs. We concur that the most critical service needs are crisis intervention, family support, and assessment services, as well as increasing the number of foster care families.

We appreciate the \$750,000 in funds that the General Assembly provided for the CSA Innovative Community Services Grants program and we support JLARC's recommendation to expand funding for this program (*Recommendation #18*). We also concur with JLARC's recommendation that the State consider allowing communities to reinvest a portion of funds identified through avoided cost increases due to lower per child costs in developing new community services (*Recommendation #19*).

Improving access to information on residential care providers. We concur with the recommendations to improve access to information so that communities can make appropriate and cost effective decisions with children and families:

- Adding fields to the child data set to capture reasons services ended, residential care providers, and child outcomes. (*Recommendation #11 and #14*)
- Requiring standard child outcome measures through provider contracts. (*Recommendation #13*)
- Developing a standardized information system that will enable regulatory agencies to report licensing and compliance data to OCS. (*Recommendation #22*)
- Replacing the service fee directory with a system that provides information on compliance with standards, child outcomes, and financial information for residential providers (*Recommendation #21*). OCS and the Commission on Youth both identified this need as well. OCS decided to wait for JLARC's recommendation to prevent revising the directory twice.

OCS is a small office with limited technology expertise and resources. It is critical that we have the assistance of the Secretary of Technology to accomplish this significant scope of work. It is also essential that communities are involved to ensure that the tools developed meet their information needs. Finally, OCS may need additional resources to manage the system.

JLARC concludes that outcome information for children in residential care is mixed and the data needs to be improved in Virginia. The CSA Joint Subcommittee may wish to review the national research on residential care.

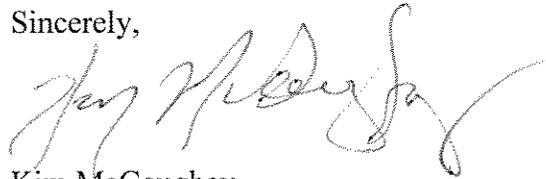
Strengthening local CSA systems. OCS will continue to work in partnership with communities to strengthen their local CSA systems. We fully concur with JLARC's recommendations to:

- Increase funding for localities to effectively implement this program by employing a CSA coordinator and utilization management person based on caseload size. Utilization management is a critical technology that has proved effective in managed care to ensure appropriate and cost-effective services. While this function can be performed at the state level, it is more effective at the local level because this person will know the children, families and community resources (*Recommendation #25*).
- Strengthening the role of CSA Coordinators, CPMTs and FAPTs (*Recommendations #26, #27, and #28*). With the current level of funding available for CSA Coordinators, it is not feasible for CSA

Coordinators across the state to have similar job responsibilities. OCS has focused on sharing with communities the functions required for managing an effective CSA system. Communities currently must split these functions across their CPMT Chair, CSA Coordinator, FAPT Chair, and fiscal and program staff based on their unique organizational structures and local resources. If the state provides adequate funding for communities, more CSA Coordinators could assume comparable functions. However, there will always be some differences based on the unique infrastructure and needs of communities.

Again, thank you for the opportunity to comment on the JLARC report. I enjoyed working with the JLARC team and appreciate their hard work to improve the CSA system. As always, I am happy to discuss our comments with you.

Sincerely,

A handwritten signature in black ink, appearing to read "Kim McGaughey". The signature is fluid and cursive, with a long, sweeping tail that extends to the right.

Kim McGaughey
Executive Director



DEC - 1 2006

COMMONWEALTH of VIRGINIA

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November 23, 2006

Mr. Philip A. Leone
Director
Joint Audit and Review Commission
Suite 1100, General Assembly Building
Richmond, Virginia 23219

Dear Mr. Leone:

Thank you for the opportunity to review and provide comments and suggestions on the Executive Summary and Chapters 2 and 3 of the exposure draft of the report, Evaluation of Children's Residential Services Delivered Through the Comprehensive Services Act. We found the report to be substantive and meticulous. We commend your staff for their professionalism.

Staff from the agency met with the Coordinating Committee for Interdepartmental Regulations that include the Departments of Education, Social Services, Juvenile Justice, and Mental Health, Mental Retardation, and Substance Abuse Services. Under separate cover, you may expect to receive the committee's response to the report from Chairman Wallace G. Harris.

Sincerely,

A handwritten signature in cursive script, appearing to read "Billy K. Cannaday, Jr.", with a large flourish at the end.

Billy K. Cannaday, Jr.

BKCJr/SER



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