VCOPPA

Virginia Coalition of Private Provider Associations

14th ANNUAL CRITICAL ISSUES SYMPOSIUM

NOVEMBER 11-12, 2015

SunTrust Center
Richmond, Virginia

VIRGINIA COALITION OF PRIVATE PROVIDER ASSOCIATIONS

Presents

14th ANNUAL VCOPPA CRITICAL ISSUES SYMPOSIUM

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Table of Contents

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Schedule

Wednesday, November 11, 2015

1:00 p.m. *Registration*

1:30 p.m. *Welcome and Introductions* – Debbie Pell, VCOPPA President

2:00 p.m. **MODULE A**
Magellan Turns Three:
An Update from Virginia's Behavioral Health Services Administrator

James (Jim) Forrester, Ed.D., System of Care Director, Magellan of Virginia

3:00 p.m. **MODULE B**
A Preview of Child and Family Advocacy Issues / Legislative Priorities for 2016

Jennifer Fidura, Executive Director, Virginia Network of Private Providers
Christie Marra, Staff Attorney, Virginia Poverty Law Center
James Pickral, Legislative Counsel, Virginia League of Social Service Executives
Mira Signer, Executive Director, NAMI Virginia
Amy Woolard, Senior Policy Attorney, Voices for Virginia's Children

4:00 p.m. **MODULE C**
An Analysis of 2015 General Assembly Election Results

William P. Elwood, VCOPPA Executive Director

5:15 p.m. Reception at SunTrust Center, 4th Floor Mezzanine

Thursday, November 12, 2015

8:00 a.m. Registration and Breakfast – 4th Floor Lobby

8:30 a.m. **MODULE D**
Critical State Budget Issues Facing Virginia, Now and in the Future

James J. Regimbal, Jr., Fiscal Analytics, Ltd.

9:30 a.m. **MODULE E**
Where We Are Headed With the Children's Services Act

Scott Reiner, Interim Executive Director, Office of Children's Services

10:15 a.m. **MODULE F**
Update on DMAS Regulatory Changes for Residential Treatment Services

Brian Campbell, Senior Policy Analyst, Division of Integrated Care and Behavioral Services
Department of Medical Assistance Services

11:15 a.m. **MODULE G**
Virginia Commission on Youth Study on the Use of Federal, State and Local Funds for Private Educational Placements of Students with Disabilities

Leah D. Mills, Senior Legislative Policy Analyst, Virginia Commission on Youth

12:00 p.m. Lunch – 4th Floor Lobby

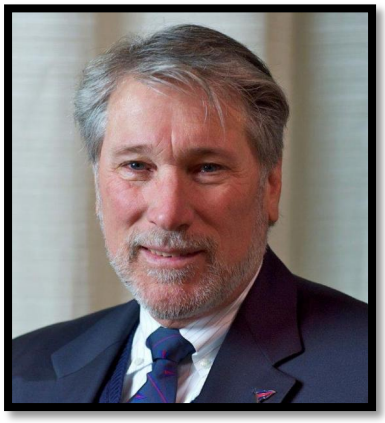
1:00 p.m. **SPECIAL WORKSHOP**
Private Schools Regulations Workshop: Regulations Governing the Operation of Privates Schools with Disabilities

Presented by the Virginia Department of Education
Office of Dispute Resolution and Administrative Services
(NOTE: This is a training session to provide technical assistance to local educational agency and private school staff, as well as representatives of various private school accrediting agencies to assist them in the implementation of the new regulations.)

3:00 p.m. *Adjournment* – **Debbie Pell, VCOPPA President**

2015 Symposium Presenter Biographies

James (Jim) Forrester, Ed.D., System of Care Director



Jim Forrester, Ed. D. is Director, System of Care for Magellan Behavioral Health of Virginia. Jim assumed this role in October of 2013 and is responsible for leading the strategy and planning efforts in system transformation, helping behavioral health systems evolve and expand using a strengths-based, regionally focused multi-year approach.

Prior to his current role, Jim served as Clinical Director for Optima Behavioral Health, which manages behavioral health services for Medicaid, commercial insurances and employee assistance programs. He also served as Vice President of Clinical Services for Magellan, providing management of the behavioral health benefits for state employees as well as several other commercial clients.

Before working in managed care, Jim owned a private psychological practice with offices in Virginia Beach and Newport News, Va. He holds a doctorate in counseling from the College of William and Mary. Jim has lived in Norfolk for 38 years. He enjoys sailing and holds a Coast Guard license as a Master for vessels less than 50 tons.

Jennifer Fidura, Executive Director, Virginia Network of Private Providers

Jennifer Fidura has been providing supports in one capacity or another for individuals who are DD/ID for more than forty years. When she came to Virginia in 1981 it was as Director of what is now Central Virginia Training Center in Lynchburg; she left state government in 1990 as Deputy Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services (now the Department of Behavioral Health and Developmental Services).

Since 1990 she has owned and operated Fidura & Associates, a company providing a variety of community supports for persons with intellectual and mental disabilities across the Commonwealth. She is also actively involved in the Virginia Network of Private Providers and ANCOR, trade associations for community providers on the state and national level. Jennifer serves as the spokesperson for VNPP on a number of committees and is their lobbyist at the Virginia General Assembly.

Christie Marra, Staff Attorney, Virginia Poverty Law Center

Since September, 2004, **Christie Marra** has been a staff attorney with the Virginia Poverty Law Center, Inc. specializing in family law, children's rights and legal issues related to rental housing. Prior to coming to the Virginia Poverty Law Center, Inc. she worked as a family and housing law attorney for Central Virginia Legal Aid Society, Inc. in Richmond for thirteen years and before that worked briefly as a staff attorney for the local legal aid program serving the seven counties in far southwest Virginia. Christie earned her J.D. from the T.C. Williams School of Law at the University of Richmond in 1991 and earned a B.A. from the University of Virginia in 1988. Christie was a member of the former First Lady's *For Keeps* advisory panel and is an *ad hoc* member of the Virginia League of Social Services Executive's Child and Family Services committee. She also recently joined the Board of Directors of Housing Opportunities Made Equal. Christie was the recipient of the Family Law Service Award by the Family Law Section of the Virginia State Bar in 2010 and received the Virginia Legal Aid Award from the VSB in 2014.

James Pickral, Legislative Counsel, Virginia League of Social Service Executives

James A. Pickral, Jr. has significant experience in the economic development, renewable and alternative energy, and pharmaceutical industries, with a focus on health care legislative and regulatory issues.

James has over a decade of experience in government affairs and previously served as Manager of State Government Affairs for Troutman Sanders Strategies. While there, he represented such diverse clients as pharmaceutical manufacturers, economic developers, hospital systems, and an alternative and renewable energy association among others.

James also served as the Director of Policy for the Virginia Pharmacists Association where he was responsible for developing association policy and advocating on the state and federal levels. While at the Virginia Pharmacists Association, James was the federal point person for the Virginia members of the National Association of Compounding Pharmacists and the National Community Pharmacist Association. James' legislative experience also includes serving three sessions as Legislative Assistant to Delegate John O'Bannon.

James has been involved in several state and federal public health and safety campaigns including the "Virginia Meth Watch Program" instituted by former Attorney General Jerry Kilgore, aimed at reducing methamphetamine production. He served as the Virginia representative and the Virginia program coordinator for the Food and Drug Administration's "Looks Can Be Deceiving" campaign, which educates the public on the risks associated with illegally imported prescription drugs.

James is a veteran of the U.S. Army, serving as an infantryman during Operations Desert Shield, Desert Storm, and Provide Comfort. After his military service, James attended Virginia Commonwealth University graduating in 2000 with a Bachelor of Arts in History and a minor in German.

2015 Symposium Presenter Biographies

Mira Signer, Executive Director, NAMI Virginia

Mira Signer joined National Alliance on Mental Illness of Virginia (NAMI Virginia) as the Executive Director in July 2007. Along with public policy, grassroots advocacy, program development, and nonprofit expertise, Mira brings her personal experiences, challenges, and lessons learned of friends and loved ones' with mental illness, which is part of her motivation to reduce stigma of mental illness and improve Virginia's mental health system.

In her role as Executive Director, Mira provides direction and leadership toward the achievement of NAMI Virginia's mission and philosophy. Mira received her Masters in Social Work-Administration, Planning, and Policy Practice from Virginia Commonwealth University and a Certificate in Nonprofit Management from VCU.

In 2011 Ms. Signer was recognized as one of *Style Weekly's Top 40 Under 40*. Mira received her undergraduate degree from James Madison University where she was a varsity student-athlete and active in JMU's Community Service-Learning program. Mira is originally from Arlington, Virginia.

Amy Woolard, Senior Policy Attorney, Voices for Virginia's Children

Amy Woolard is Senior Policy Attorney with Voices for Virginia's Children, a statewide policy research & advocacy organization, focusing on child welfare, foster care, juvenile justice, youth homelessness, and family poverty.

In addition to administrative and legislative policy advocacy, Amy also writes for publications such as Slate, Pacific Standard, and the Clearinghouse Review. She frequently presents on policy topics at both state and national conferences, & has also taught policy seminars at the University of Richmond School of Law, Georgetown University, & VCU School of Social Work.

In 2015, she was appointed by Governor McAuliffe to the Virginia Juvenile Justice Advisory Committee, and is also a member of the Governor's Advisory Council on Homelessness. Amy received her J.D. from the University of Virginia School of Law. She also holds an M.F.A. from the University of Iowa Writers' Workshop and an M.S. in Communications from Virginia Commonwealth University.

2015 Symposium Presenter Biographies

William P. Elwood, VCOPPA Executive Director

Bill Elwood is President and CEO of Elwood Consulting, LLC, a Richmond-based lobbying, association management and business to government consulting firm and has extensive association management and government relations experience, with 35 years working in Virginia government, the last 32 as a registered lobbyist. In particular, he has developed an expertise in the Virginia state budget. He has also enjoyed close bipartisan relationships in the executive and legislative branches, along the way earning a reputation for professionalism, integrity and expertise in the government relations community.

Elwood has been deeply involved in the association management community, where he is a past President of the Virginia Society of Association Executives (VSAE) and a member of the American Society of Association Executives (ASAE) for the last twenty-two years. In 2002, Elwood was presented by his peers the VSAE Award of Excellence in honor of his accomplishments in the association management profession. As an independent contractor, Elwood currently serves as Executive Director of two associations, the Virginia Coalition of Private Provider Associations and the Virginia Association of Independent Specialized Education Facilities.

James J. Regimbal, Jr., Fiscal Analytics, Ltd.

Jim Regimbal has 33 years of experience in state and local budget and tax policy analysis. He served for 12 years on the staff of the Virginia Senate Finance Committee from 1987-1999, where he provided the Committee with expertise in tax policy, economic and revenue forecasting and transportation and finance agency budgets.

In 1999, he co-founded Fiscal Analytics Ltd. where his expertise in state and local budget and tax policy issues have been provided to local governments, business groups, trade associations, and nonprofit organizations. His local government clients currently include the Virginia Association of Counties, the Virginia Municipal League, and the Virginia First Cities Coalition. Past clients have included the Virginia Hospital & Healthcare Association (VHHA) and the Virginia Health Care Association (VHCA).

Mr. Regimbal holds a B.S. in Economics from the University of Pacific, and an MBA from Virginia Commonwealth University. Jim has been married for 31 years and has three sons.

2015 Symposium Presenter Biographies

Scott Reiner, Interim Executive Director, Office of Children's Services

Scott Reiner is the presently the Interim Executive Director at the Office of Children's Services where he is been responsible for all administrative functions of the Office. He has been at OCS for two years and until assuming the Interim role, was the Assistant Director, coordinating training and technical assistance activities, the Office's outcomes management initiative, and leading improvements to the statewide system of care. He came to OCS after 26 years at the Virginia Department of Juvenile Justice. Scott has a master's degree in clinical psychology and been closely involved in improving practices for children and adolescents with behavioral health issues across child serving agencies. As the father of three children, he has a special appreciation for the challenges of guiding young people successfully to adulthood.

Brian Campbell, Senior Policy Analyst, Division of Integrated Care and Behavioral Services, Department of Medical Assistance Services

Brian Campbell has years of experience working with administering programs for children with developmental and behavioral health needs. From 2005-2013 he supervised the Medicaid children's benefit known as the EPSDT program. During that time he implemented extensive program changes and enhancements to better meet the medical and behavioral health needs of children enrolled in Virginia's Medicaid program. Since January, 2014 he has served as the Behavioral Health Policy Analyst for the Department of Medical Assistance Services (DMAS). He is part of the team responsible for implementing significant program policy and regulatory changes being implemented by the DMAS Integrated Care and Behavioral Health Services

Leah D. Mills, Senior Legislative Policy Analyst, Virginia Commission on Youth

Leah Mills is a Senior Policy Analyst with the Virginia General Assembly's Commission on Youth. In this position, Ms. Mills analyzes issues affecting Virginia's youth and their families. Ms. Mills serves as lead analyst for Commission's studies on topics ranging from education, mental health, juvenile justice, and child welfare. Prior to working with the General Assembly, Ms. Mills worked for the Department of Medical Assistance Services as the Interim Director of Communications and Legislative Affairs.

Ms. Mills received her Bachelors of Justice and Risk Administration from Virginia Commonwealth University and a Master of Public Administration from Virginia Polytechnic Institute and State University. She is currently a member of the Virginia Board of Counseling, the Virginia Juvenile Justice and Child Welfare Multi-System Integration Team, and has served on a variety of task forces that address youth and family issues. She volunteers for Chesterfield County Court Appointed Special Advocates (CASA) and is a member of United Methodist Women with Bethia United Methodist Church. Ms. Mills is resides in Chesterfield Virginia with her husband. She has one grown son and two grown stepchildren.

VCOPPA would like to thank our Sustaining Members for their ongoing support of the Coalition.

For details on membership, please visit the Coalition website.
www.VCOPPA.org

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Hallmark Youthcare
Improving Outcomes, LLC
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Reception Sponsors

A special thanks to the sponsors of this year's reception.

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NOTES

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2015 Election Analysis

Virginia General Assembly Races

2015 Election Analysis

Virginia House of Delegates Races

Virginia House of Delegates

- All 100 seats were up for election
- Pre-Election party breakdown: 67-R 33-D
- Unopposed 71 (30 in 2009): 44 (20) R 27 (9) D
- Open seats (11 retirements / 1 primary defeat):
- Contested w/D & R 29 (56 in 2009):
  - Few Incumbents “In Play” on either side

Virginia House of Delegates

- November 3rd Results:
  - New party breakdown: 66-R 34-D
- Of 29 contested (D & R), only 7 were "competitive"
  - Competitive = Winner less than 55%
- Of 7 competitive, only 3 had margin of less than 3%
- No incumbent Delegate lost in General Election; only 3 open seats changed parties (2 R, 1 D) = +1 for D

Virginia House of Delegates

Closer look at the seven "competitive" House races:

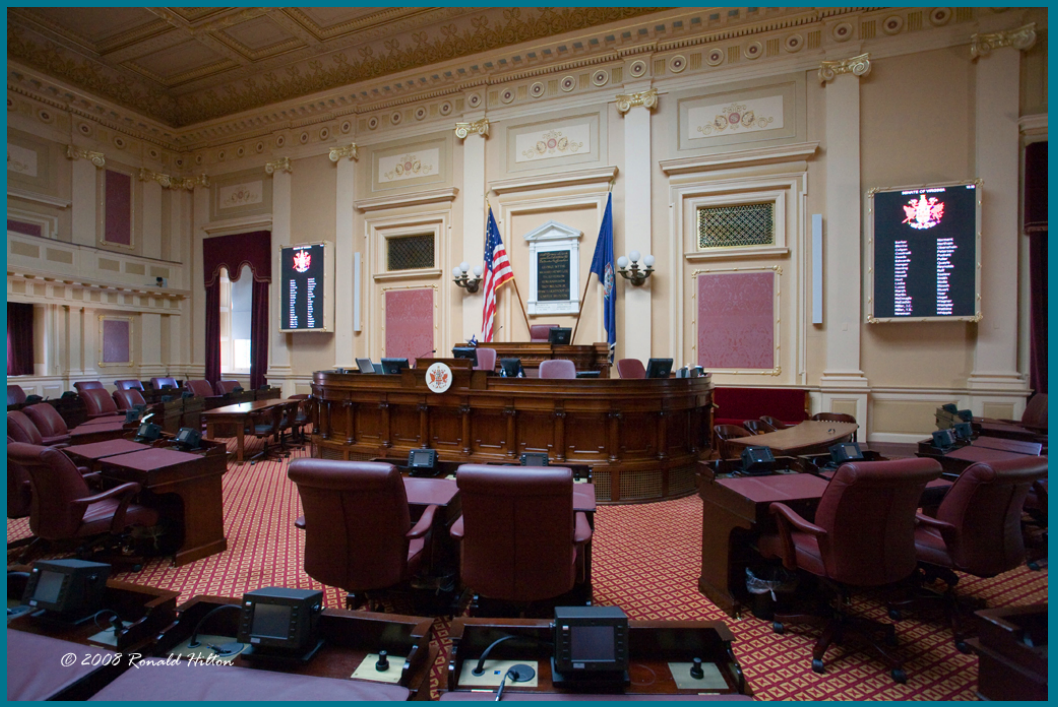
- House District #34 (Fairfax/Loudoun) – D incumbent
  - Murphy (D) wins with 50.4%, margin 0.89% (+191 votes)
- House District #2 (Prince William/Stafford) – Open D seat (Futrell)
  - Dudenhefer (R) wins with 51.1%, margin 1.1% (+118 votes)
- House District #87 (Loudoun/Prince William) – Open R seat (Ramadan)
  - Bell (D) wins with 49.8%, margin 1.9% (+315 votes)
- House District #32 (Loudoun) – R incumbent
  - Greason (R) wins with 51.9%, margin 4%
- House District #31 (Prince William/Fauquier) – R incumbent
  - Lingamfelter (R) wins with 53.3%, margin 6.8%
- House District #93 (James City/York/Newport News/Williamsburg) – D incumbent
  - Mason (D) wins with 54.6%, margin 9.5%
- House District #86 (Fairfax/Loudoun) – Open R seat (Rust)
  - Boysko (D) wins with 54.4%, margin 14.1%

Virginia House of Delegates

- What was at stake? *Not much!*
  - Organizational control of the House
    - Speakership
    - Committee Chairs
    - Committee Membership
    - Budget Conferees
    - R's keep control 2 of the "Big 3": House, Senate; D Governor
  - **Silver lining for D's**
    - 33 to 34 seats exceeds "super veto" threshhold

2015 Election Analysis

Virginia State Senate Races



Senate of Virginia

- All 40 seats were up for election
- Previous party breakdown: 21 (R) 19 (R) Lt. Gov (D)
- Unopposed 20 (14 in 2011): 10 (11) (R) 10 (3) (D)
- Open seats (6 retirements + 1 primary defeat)
- Contested w/D & R (20):
  - 6 seats were considered “In Play”: 3 (D) 3 (R)

Senate of Virginia

- November 3rd Results:
  - New party breakdown: 21 (R) 19 (R) Lt. Gov (D)
- Of 20 contested (D & R), only 7 were "competitive"
  - Competitive = Winner less than 55%
- Of 7 competitive, only 1 had margin less than 5%
- No incumbent Senator lost in General Election; all 40 seats stayed with same party as before = 0 net change

Senate of Virginia

Closer look at the seven "competitive" Senate races:

- Senate District #10 (Richmond City/Chesterfield/Powhatan) – Open R seat (Watkins)
  - Sturtevant (R) wins with 49.6%, margin 2.7%
- Senate District #13 (Loudoun/Prince William) – R incumbent
  - Black (R) wins with 52.2%, margin 5.2%
- Senate District #39 (Alexandria/Fairfax/Prince William) – D incumbent
  - Barker (D) wins with 53.6%, margin 7.7%
- Senate District #29 (Prince William/Manassas) – Open D seat (Colgan)
  - McPike (D) wins with 53.8%, margin 8%
- Senate District #21 (Roanoke/Montgomery/Giles) – D incumbent
  - Edwards (D) wins with 50.8%, margin 8.3%
- Senate District #7 (Virginia Beach/Norfolk) – R incumbent
  - Wagner (R) wins with 53.6%, margin 8.3%
- Senate District #37 (Fairfax) – D incumbent
  - Marsden (D) wins with 55.4%, margin 10.1%

Senate of Virginia

- What was at stake?
  - Organizational control of the Senate
    - Republican Control of Both Houses of the General Assembly
    - Committee Chairs
    - Committee Membership
    - Budget Conferees
  - Medicaid Expansion – McAuliffe Legacy

Changing Demographics of Virginia General Assembly

2016 House of Delegates:

- 75/100 elected since 2005 (>10 years experience)
- 12/100 retired/lost primaries for 2015 elections

2016 Senate of Virginia:

- 28/40 elected since 2005 (>10 years experience)
- 7/40 retired/lost primaries for 2015 elections
- 25% of total years of service left in 2015

Preview of 2017 Virginia Statewide Elections


Northam


Gillespie


Cuccinelli


Wittman

Candidates for Governor of Virginia:

- *Democratic:* Lieutenant Governor Ralph Northam
- *Republican:* Former RNC Chair Ed Gillespie
- *Republican:* Former AG Ken Cuccinelli
- *Republican:* Congressman Rob Wittman (VA – 1st District)

LOBBYIST

What my friends think I do.

What my parents think I do.

What the other side says I do.

What society thinks I do.

What I think I do.

What I actually do.

Level C Residential Treatment Program Requirements

Residential treatment program is a 24-hour, supervised, clinically and medically necessary, out-of-home program designed to provide necessary support and address mental health, behavioral, substance abuse, cognitive, or training needs of an individual under 21 years of age in order to prevent or minimize the need for more intensive inpatient treatment. Active treatment and comprehensive discharge planning for aftercare placement and treatment must begin at admission. The discharge plan must meet the medical and clinical needs of the individual.

Services include, but shall not be limited to, assessment and evaluation, medical treatment (including medication), individual, family, and group therapies provided by LMHP or LMHP resident/supervisee, and other appropriate mental and mental health interventions. The service provides active treatment or training beginning at admission related to the resident's diagnosis.

Required Activities - LOC Requirements

Milieu based structure for therapeutic activities, including:

Restoration, development or maintenance of:

- anger management,
- family living skills,
- interpersonal skills,
- communication skills, and
- stress management strategies
- Individualized activities in accordance with the CIPOC
- *Three daily treatment* ***interventions*** *or psychoeducational activities as outlined in the treatment plan and/or aligned with the treatment goals* identified in the individual plan of care (interventions and activities are provided in addition to individual, group and family therapies and family involvement activities) *with documentation to justify clinical or medical reasons for the deviations from the service plan.*

  "Interventions" *consist of:*
  medical treatments,
  individual or group psychoeducation or psychoeducational activities with specific topics focused to individual needs;
  insight-oriented and/or behavior modifying activities

  We need to consider how to address the following items/"interventions" in the milieu:

  - *art,*
  - *medical,*
  - *Music therapies,*
  - *Community activities for generalization,*
  - *rec therapies*
  - *Consider use of therapeutic passes and family work in milieu requirement*

Clinical Requirements in addition to the Milieu include, but shall not be limited to:

- The service provides treatment or training as documented in the POC beginning at admission related to the resident's diagnosis.

- assessment and evaluation,
- Diagnosis must result from a face to face psychiatric evaluation DSM-5/ICD-10 diagnosis
- medical treatment (including medication), and coordination of necessary medical services
- individual, family, and group therapies provided by LMHP or LMHP resident/supervisee, and other appropriate mental and behavioral health interventions. *(six session review-DHP need to include as DMAS requirement or not?)* *(facility/mileu therapies and ancillary therapies too)*
- 24 hour onsite nursing
- Once weekly psychiatric re-assessments
- Family therapy face to face (or telemedicine) as appropriate provided by LMHP LMHP-supervisee, LMHP-resident, or LMHP-RP
- Family involvement at least once per week to include: Family psychoeducational training/coaching Transition planning, family/ independent living skills; community access training. Under certain circumstances an alternate plan for family or natural supports, aimed at enhancing the individual's connections with other family members and/or supportive adults may be an appropriate substitute.
- Family and Locality based Care Coordination/discharge planning begins immediately upon admission to RTC with the goal of transitioning the individual out of the program to a less restrictive care setting for continued, sometimes intensive, services as soon as possible and appropriate.
- Individual Therapy 3 times per week at a minimum or more based upon child's needs provided by LMHP LMHP-supervisee, LMHP-resident, or LMHP-RP
- Group psychotherapy coverage is limited to once per day.
- Psychotropic medications, when used, are to be used with specific target symptoms, and
- Evaluation for current medical problems
- Linkage and/or coordination with the patients community resources with the goal of returning the patient to his/her regular social environment as soon as possible, unless contraindicated. School contact should address educational transition needs as appropriate.
- behavioral health treatment related to the diagnosis
- Initial plan of care must be completed within 24 hours of admission and a Comprehensive Individual Plan of Care (CIPOC) must be completed no later than 1 days after admission.
- Persons aged 18 years and above must be pre-approved in writing by DBHDS

Discharge Planning and Care Coordination Requirements

Upon admission:

1. Care coordination and comprehensive discharge planning for aftercare placement and treatment must begin at admission.
2. Information is obtained from families, medical and mental health treatment providers, school, social services, court services, etc. in a timely manner. *(how to address deficits from non-Medicaid entities)* ***IEP*** *is the most significant/common problem. Universal FERPA/HIPAA consent form may address this*
3. This information is used to inform the plan of care and discharge planning.
4. Admissions for persons aged 18 and older must be prior approved in writing by DBHDS.

During treatment:

1. The family, guardian is involved with the child and treatment team on an ongoing basis with treatment planning.
2. The CSB, FAPT case manager, MCO or Magellan care coordinator is involved with the child and treatment team on an ongoing basis with the treatment planning *(needs to be addressed in CON process) Ideally, ensure ICC is in place upon admission*

3. In collaboration the facility the CSB, FAPT case manager, MCO or Magellan care coordinator will identify the child and family needs and available services in the community

Pre-discharge:

1. Upon submission and review of the active discharge plan by Magellan/MCO, the provider must identify and begins collaboration with the guardian to ensure that psychiatric and medical providers appointments are scheduled,(CMHRS/CSA) service intakes are scheduled and information is shared with all involved providers.
2. Identify service needs for aftercare, provide update to care coordinators at Magellan/MCO to ensure services are in place based on the needs of the individual.
3. Identify community based providers and identify service planning is occurring prior to discharge in "return" community using the local and facility treatment teams
    a. Ensure school enrollment,) Includes IEP recommendations, if necessary,
4. Providers must get the active discharge plan reviewed with Magellan to ensure required activities for the individual are present and to ensure care coordination occurs to facilitate the referral and activation of aftercare services
5. Include ICC as available
6. Residential Provider must coordinate with local treatment team linkages with service providers, other community- based resources will occur as possible, time in accordance with discharge needs.
7. *ICC will begin 90 days* prior to planned discharge. *(pending local FAPT/CPMT choice)*
8. Reasonable efforts are made to ensure passes occur to meet with treatment providers, be at home, and otherwise prepare for discharge.
9. Passes will be paired with facility-based treatment activities to promote discharge success (e.g., family therapy) and family engagement.
10. Number and extent of day and overnight passes should be based upon child/family need rather than limited to predetermined number of passes (cumulative pass days beyond 24 must be preauthorized). *Remove "building" requirement of day to overnight progression, allow to be individualized, consider authorizing passes after thresholds etc. implement as clinically indicated.*

Plan of Care/CIPOC

Add IMD requirements

Include the MD signature for IMD requirements and plan addendums

- The CIPOC for Level C must meet all of the following criteria:

- Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the recipient's situation and must reflect the need for inpatient psychiatric care;

- Be developed by an interdisciplinary team of physicians and other personnel specified under subsection F of this section, who are employed by, or provide services to, patients in the facility in consultation with the recipient and his parents, legal guardians, or appropriate others in whose care he will be released after discharge;

- State treatment objectives that must include *measurable* short-term and long-term goals and objectives, with target dates for achievement;

- Prescribe an individualized integrated program of therapies, activities, and experiences designed to meet the treatment objectives related to the diagnosis; and

- Describe comprehensive discharge plans and coordination of inpatient services and post-discharge plans with related community services to ensure continuity of care upon discharge with the recipient's family, school, and community. The discharge plan

- The CIPOC must be reviewed every 30 days by the treatment team to determine that services being provided are or were required at the present level of care; and The CIPOC must be reviewed, signed, and dated every 30 days by the treatment team responsible for providing direct services to the individual including the QMHP for Level A and by the LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP for Level B. The review must be documented by dated signatures of the treatment team which includes the family/guardian and individual receiving services (use CMHRS reg language).

- Recommend changes in the plan as indicated by treatment progress and treatment outcomes.

Progress Monitoring

Need Magellan suggestions guidelines here:

Use of the CANS to assess ongoing progress is required in addition to the treatment plan requirements.

Provider must complete CANS on a routine basis- to be specified

Treatment plan progress data is measureable, evidence based

- When issues were identified a plan was devised and implemented to correct those issues;
- Actual data collected;
- Evidence of regular and ongoing analysis of the overall program data;
- Evidence of regular and ongoing analysis of each individuals data;
- Evidence that any issues identified, including a lack of sufficient progress to meet individual or overall program goals or objectives have resulted in actions being taken to remediate the identified issues;
- Evidence of ongoing evaluation of the effectiveness of those changes in remediating the identified issues.

Ensure evidence based approach is used/incorporated

Member specific data based on measureable treatment plan objectives.

Therapeutic Group Homes (former Level A/B) Program Requirements

Service Definition

Therapeutic Group Home Services for Children and Adolescents under the age of 21 are a combination of therapeutic services rendered in a residential setting. This service will provide a therapeutic structure for psychoeducational activities, therapeutic supervision and treatment, and mental health care to ensure the attainment of therapeutic mental health goals as identified in the ISP. The individual must also receive individual and group psychotherapy services, at least weekly, in addition to the therapeutic residential services' and family therapy as recommended. The Therapeutic Group Home program design must incorporate nationally established, evidence based, trauma-informed services and supports that promote recovery and resiliency.

Required Activities - LOC Requirements

Milieu based structure for therapeutic activities, including:

Restoration, development or maintenance of:

- anger management,
- family living skills,
- interpersonal skills,
- communication skills, and
- stress management strategies
- Individualized activities in accordance with the CIPOC
- *Once daily treatment* ***interventions*** *or psychoeducational activities as outlined in the treatment plan and/or aligned with the treatment goals* identified in the individual plan of care (interventions and activities are provided in addition to individual, group and family therapies and family involvement activities) *with documentation to justify clinical or medical reasons for the deviations from the service plan.*

  "Interventions" *consist of:*
  medical treatments,
  individual or group psychoeducation or psychoeducational activities with specific topics focused to individual needs;
  insight-oriented and/or behavior modifying activities

  We need to consider how to address the following items/"interventions" in the milieu:

  - *art,*
  - *medical,*
  - *Music therapies,*
  - *Community activities for generalization,*
  - *rec therapies*
  - *Consider use of therapeutic passes and family work in milieu requirement*

Clinical Requirements in addition to the Milieu:

- Behavioral health treatment related to the principle diagnosis

- Diagnosis must result from a face to face psychiatric evaluation to support the DSM-5/ICD-10 diagnosis *(DMAS needs to modify program manual to allow reimbursement for activity)* Preadmission Intake by (LMHP), LMHP-supervisee, LMHP-resident, or LMHP-RP
- Weekly individual psychotherapy in the group home provided by LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP
- Group psychotherapy provided by LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP minimally 1 time per week as included in the service plan/***as clinically indicated***
- Family therapy as appropriate provided by LMHP LMHP-supervisee, LMHP-resident, or LMHP-RP ***as clinically indicated***
- Family involvement at least monthly to include: Family psychoeducational training/coaching Transition planning, family/ independent living skills; community access training. Under certain circumstances an alternate plan for family or natural supports, aimed at enhancing the individual's connections with other family members and/or supportive adults may be an appropriate substitute.
- Family and Locality based Care Coordination/discharge planning begins immediately upon admission to Therapeutic Group Home with the goal of transitioning the individual out of the program to a less restrictive care setting for continued, sometimes intensive, services as soon as possible and appropriate.
- Crisis Management, clinical assessment and individualized counseling when necessary to address intermittent behavioral challenges within the group home setting and to avoid a higher level of care as clinically indicated
- Care Coordination with medical educational other MH providers and other entities involved in the care and discharge planning for the individual

Discharge Planning and Care Coordination Requirements

Upon admission:

1. Care coordination and comprehensive discharge planning for aftercare placement and treatment must begin at admission.
2. Information is obtained from families, medical and mental health treatment providers, school, social services, court services, etc. in a timely manner.
3. This information is used to inform the plan of care and discharge planning.
4. Admissions for persons aged 18 and older must be prior approved in writing by DBHDS.

During treatment:

1. The family, guardian is involved with the child and treatment team on an ongoing basis with treatment planning.
2. The CSB, FAPT case manager, MCO or Magellan care coordinator is involved with the child and treatment team on an ongoing basis with the treatment planning *(needs to be addressed in CON process) Ideally, ensure ICC is in place upon admission*
3. In collaboration the facility the CSB, FAPT case manager, MCO or Magellan care coordinator will identify the child and family needs and available services in the community

Pre-discharge:

1. Upon submission and review of the active discharge plan by Magellan/MCO, the provider must identify and begins collaboration with the guardian to ensure that psychiatric and medical providers appointments are scheduled,(CMHRS/CSA) service intakes are scheduled and information is shared with all involved providers.
2. Identify service needs for aftercare, provide update to care coordinators at Magellan/MCO to ensure services are in place based on the needs of the individual.
3. Identify community based providers and identify service planning is occurring prior to discharge in "return" community using the local and facility treatment teams

a. Ensure school enrollment,) Includes IEP recommendations, if necessary,

4. Providers must get the active discharge plan reviewed with Magellan to ensure required activities for the individual are present and to ensure care coordination occurs to facilitate the referral and activation of aftercare services
5. Include ICC as available
6. Residential Provider must coordinate with local treatment team linkages with service providers, other community- based resources will occur as possible, time in accordance with discharge needs.
7. *ICC will begin 90 days* prior to planned discharge. *(pending local FAPT/CPMT choice)*
8. Reasonable efforts are made to ensure passes occur to meet with treatment providers, be at home, and otherwise prepare for discharge.
9. Passes will be paired with facility-based treatment activities to promote discharge success (e.g., family therapy) and family engagement.
10. Number and extent of day and overnight passes should be based upon child/family need rather than limited to predetermined number of passes (cumulative pass days beyond 24 must be preauthorized).

Plan of Care/CIPOC

For Therapeutic Behavioral Services for Children and Adolescents under 21 (Level B), the initial plan of care must be completed at admission by the licensed mental health professional LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP and a CIPOC must be completed by the LMHP no later than 30 days after admission. The assessment must be signed and dated by the LMHP.
For Community-Based Services for Children and Adolescents under 21 (Level A), the initial plan of care must be completed within 24 hours by the QMHP and a CIPOC must be completed by the QMHP no later than 30 days after admission. The individualized plan of care must be signed and dated by the program director.

- The individual's treatment goals are included in the pre-admission psychiatric or psychological evaluation and include behaviorally defined objectives that require, and can reasonably be achieved within, a ThGH setting.

Initial plan of care for Levels A and B must include:

1. Diagnoses, symptoms, complaints, and complications indicating the need for admission;
2. A description of the functional level of the child;
3. Treatment objectives with short-term and long-term goals;
4. Any orders for medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the patient;
5. Plans for continuing care, including review and modification to the plan of care; and
6. Plans for discharge.

The CIPOC for Levels A and B must meet all of the following criteria:

1. Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the child's situation and must reflect the need for residential psychiatric care;
2. The CIPOC for both levels must be based on input from school, home, other healthcare providers, the child and family (or legal guardian);
3. State treatment objectives that include measurable short-term and long-term goals and objectives, with target dates for achievement;

4. Prescribe an integrated program of therapies, activities, and experiences designed to meet the treatment objectives related to the diagnosis; and
5. Describe comprehensive discharge plans with related community services to ensure continuity of care upon discharge with the child's family, school, and community.
6. address family involvement
7. address care coordination

Progress Monitoring

Need Magellan suggestions guidelines here:

Use of the CANS to assess ongoing progress is required in addition to the treatment plan requirements.

Provider must complete CANS on a routine basis- to be specified

Treatment plan progress data is measureable, evidence based

- When issues were identified a plan was devised and implemented to correct those issues;
- Actual data collected;
- Evidence of regular and ongoing analysis of the overall program data;
- Evidence of regular and ongoing analysis of each individuals data;
- Evidence that any issues identified, including a lack of sufficient progress to meet individual or overall program goals or objectives have resulted in actions being taken to remediate the identified issues;
- Evidence of ongoing evaluation of the effectiveness of those changes in remediating the identified issues.

Ensure evidence based approach is used/incorporated

Member specific data based on measureable treatment plan objectives

Magellan Turns Three: An Update from Virginia's Behavioral Health Administrator

Virginia Coalition of Private Provider Associations

November 11, 2015

Jim Forrester, EdD, LPC

Mission

Magellan of Virginia ensures quality behavioral
health services are delivered to Virginia Medicaid enrollees. Partnering with members, providers and stakeholders, we elevate the quality and satisfaction in healthcare delivery. We work to improve the overall health and well-being of Virginians.

Purpose

- *Provide a snapshot of Magellan of Virginia activities.*
- *An emphasis on efforts to improve patient care.*
- *A focus on relationship with providers.*

Magellan HEALTH℠

Governance Board

Governance Board Overview

What is the purpose of the Governance Board?

The Governance Board will be responsible for assuring that the implementation and operation of the Behavioral Health System Administrator, as managed by Magellan Behavioral Health of Virginia for the Commonwealth of Virginia, is responsive to all stakeholder needs and is effective in considering the needs of the diverse communities of the Commonwealth. The Governance Board is the portal through which concerns about the program are systematically addressed, performance is reviewed, and recommendations for changes to the project director/general manager are made.

Total number of board members: 14

How often will the meetings take place?
The Governance Board will meet frequently at first, either in person or by telephone. Starting in 2014, the board will meet monthly or as needed.

How long will the meetings last?
Two hours each.

Will meetings be open to the public?
Yes, with the possibility for closed sessions for sensitive issues.

What are the terms of board membership?

Community and provider representatives will have one-year terms that are staggered, meaning not all terms will expire at once. Initially, three members will have one-year terms and three members will have two-year terms. (Magellan representatives will not have limited terms.)

Will the board have alternates?

Yes. Each board member, including Magellan representatives, can designate an individual to members will have voting rights when they attend a scheduled meeting in order to cover the absence of a board member.

Who makes up the Governance Board?

Community representatives (total of 7)

1 Adult service member in care

1 Family member or guardian of child/adolescent member in care

1 Advocate for mental health services

1 Advocate for substance abuse services

1 CEO/Executive from a Community Service Board (CSB) or CSB association representative

1 CEO/Executive from a private community provider or association representative

1 Health plan's medical or behavioral health representative or a community health center representative

Key areas the Governance Board will address include the following:

Suggesting clinical and training policies

Planning overall recovery/wellness policy and initiatives

Establishing and monitoring ad-hoc advisory workgroups

Monitoring member and family satisfaction

Addressing issues regarding access to and quality of care

Establishing and reviewing best practices

To whom does the board report its decisions?

The board is accountable to Magellan Behavioral Health in Virginia. Minutes will be posted to the www.MagellanofVirginia.com website

The shared Governance Board is a vehicle for the following:

Creating voice and participation in the design and implementation of operational programs of the contract for a broad base of stakeholders

Maximizing alignment among stakeholder groups

Ensuring consistent implementation of programs across the system

Identifying and recommending strategies for removing barriers to program implementation

Magellan representatives (total of 7)

Program Director/General Manager

Medical Director

Director of Quality Improvement

Director, System of Care

Director of Customer Service

Provider Relations Director

Managed Care Organization (MCO) Liaison

Continuum of Care Work Group

-First meeting was 11/5

-Included stakeholders with experience in the clinical services

- To address services for children to transition age

-To address services for adult to geriatric

-Letters of support were received from DMAS, DBHDS, DSS, DOE and OCS

-Report due 5/1/16

Magellan HEALTH℠

Learning Collaboratives

Integrated Care Learning Collaborative

-The purpose is to study the use of atypical antipsychotic medication and the existence of metabolic syndrome.

-Are members getting the appropriate labs to monitor for diabetes.

-Involves group of stakeholders familiar with issues.

Virginia's Children's Champion: A Learning Collaborative

-Looking at the use of psychotropic medication for children.

-Nationally, a well-documented problem.

-White paper and infographic on website.

-A study is being done to see if the children who are taking antipsychotic medications and antidepressants how many are having a psychosocial assessment and/or are getting other mental health services.

-Stakeholder involvement.

Recovery and Resiliency

-Recovery and resiliency as a philosophical approach to behavioral health care.

-Manager of Recovery and Resiliency.

-6 Recovery Navigators hired with GAP implementation.

-Warmline.

-Online resources: e-resource guide, e-courses, Peer Support Whole Health and Wellness e-newsletter.

-Member focused calls.

-Peer support specialist certification

Other Recent Activities

- GAP implementation: 1/15.

-ICD-10 transition: 10/1 to comply with federal regulations. Daily e-blasts.

-Elimination of fax requests for authorizations: 95% have been coming in through the web.

-NCQA this month.

-Weekly provider call.

-Newsletter and e-blasts.

Quality Improvement

Committees

The Governance Board provides oversight and support to Quality Improvement Committee and may establish ad-hoc committees which will consist of 50% Magellan staff and 50% community stakeholders. Committees will advise and report to the Governance Board but will have no decision making authority independent of the full Governance Board. Board members are expected to serve on a minimum of one committee;

Quality Improvement Committee (QIC)

Magellan improves services and care through the Quality Improvement (QI) program. The QIC directs the QI program. It does this by guiding the other committees. The QIC makes sure that the Quality Improvement program follows quality methods. It also ensures that the QI program stays on track toward goals. The QIC oversees these things:

- The program that manages how services are used
- The program that supports member recovery
- Policies
- Projects to make services better

When the QIC sees ways that we could do things better, the group will give suggestions about how to move forward. Once steps are taken to improve, the QIC will ask to see results. The group will also make certain that providers, members, families, and other stakeholders have input into our QI program.

Utilization Management Committee (UMC)

The UMC is a group that watches over our program to manage how services are used. It reviews regularly updated reports. The reports help the group to see if our services are helping members to get better. The group also monitors programs that support good care. These include:

- The program that encourages medical and behavioral health providers to work together
- The program that helps to find behavioral health problems early
- The program that helps members manage their own care
- The program that supports member recovery

Committees - continued

Member Services Committee (MSC)

The Member Services Committee (MSC) keeps track of how well member services are done at Magellan of Virginia. This group looks for ways we can serve our members better. The MSC watches over processes like these:

- How Magellan handles calls from members
- How easily members can get services from providers
- What members say Magellan does well
- What members and providers complain about
- How Magellan handles requests to change decisions about authorizing services
- Member Satisfaction Survey results
- How Magellan protects member information

Consumer, Family, Stakeholder Advisory Group (CFSAG)

The CFSAG is a subcommittee of the Member Services Committee. Magellan set up this group so that members and their families can share ideas with us. The members who are part of this group will help us learn how to make services better. Here are some of the things the group looks at:

- Member Satisfaction Survey results
- How Magellan handles grievances
- How Magellan handles requests to change decisions about authorizing services
- The Magellan Member Rights and Responsibilities Statements
- Written information for members about their benefits
- Special projects promoting wellness and recovery

Committees - continued

Regional Network Credentialing Committee (RNCC)

The RNCC sees that Magellan has quality providers. The group makes sure that we have providers that can meet member needs. A few providers are in the RNCC as well. The group helps Magellan make decisions about adding or removing providers from our network.

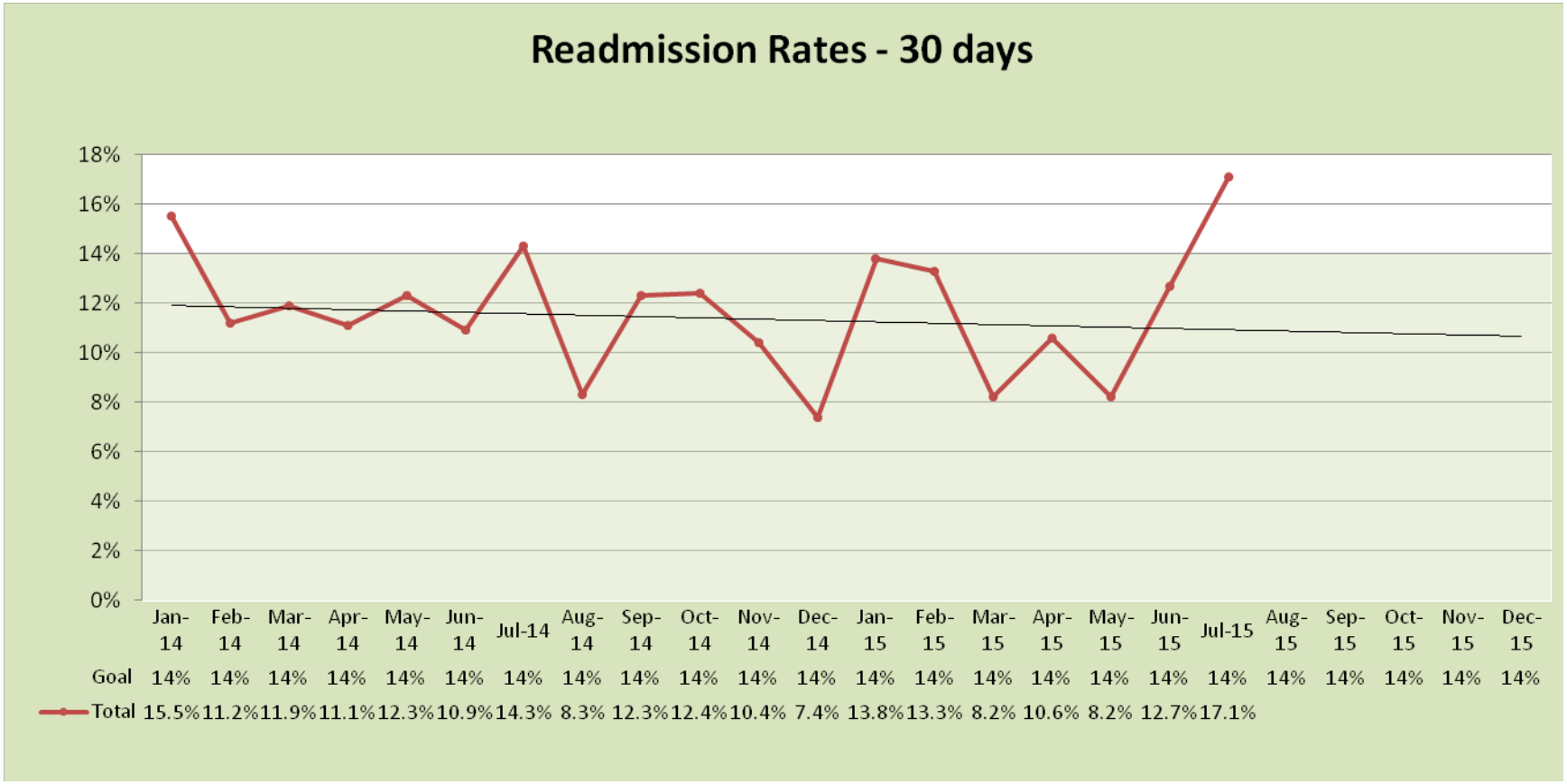
Network Strategy Committee (NSC)

The NSC reports to the RNCC. It focuses on making sure that members have good access to a range of providers across the state. The group follows access reports. Based on those reports, the NSC looks for ways to improve variety of and access to providers. It directs these changes, and watches to make sure the changes are effective.

Compliance Committee

Magellan and our providers must follow many rules. These rules come from the law, DMAS requirements, and our own policies. The Compliance Committee keeps track of how well certain rules are followed. This group considers how Magellan will respond if a rule is not followed.

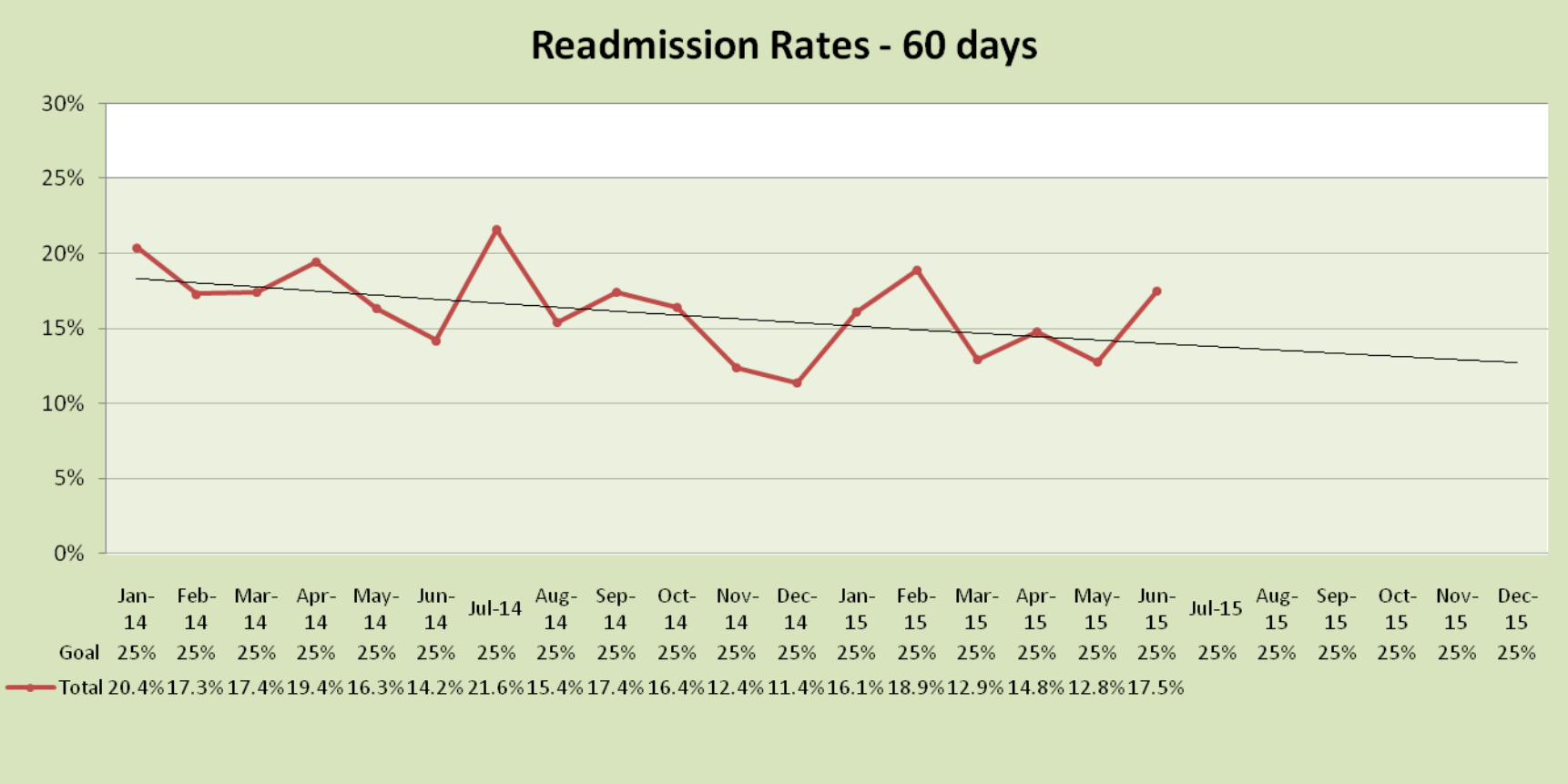
Committee Activity Highlights



4.1.1 Data Source: Enterprise based report - COWO0022A
Data as of 9/10/15

30day MH Readmission Rate: ≤14%
Readmission Rate data is reported on a 2 month lag to capture all updates.
Members re-entering an acute inpatient mental health facility within 30/60/90 days of discharge.

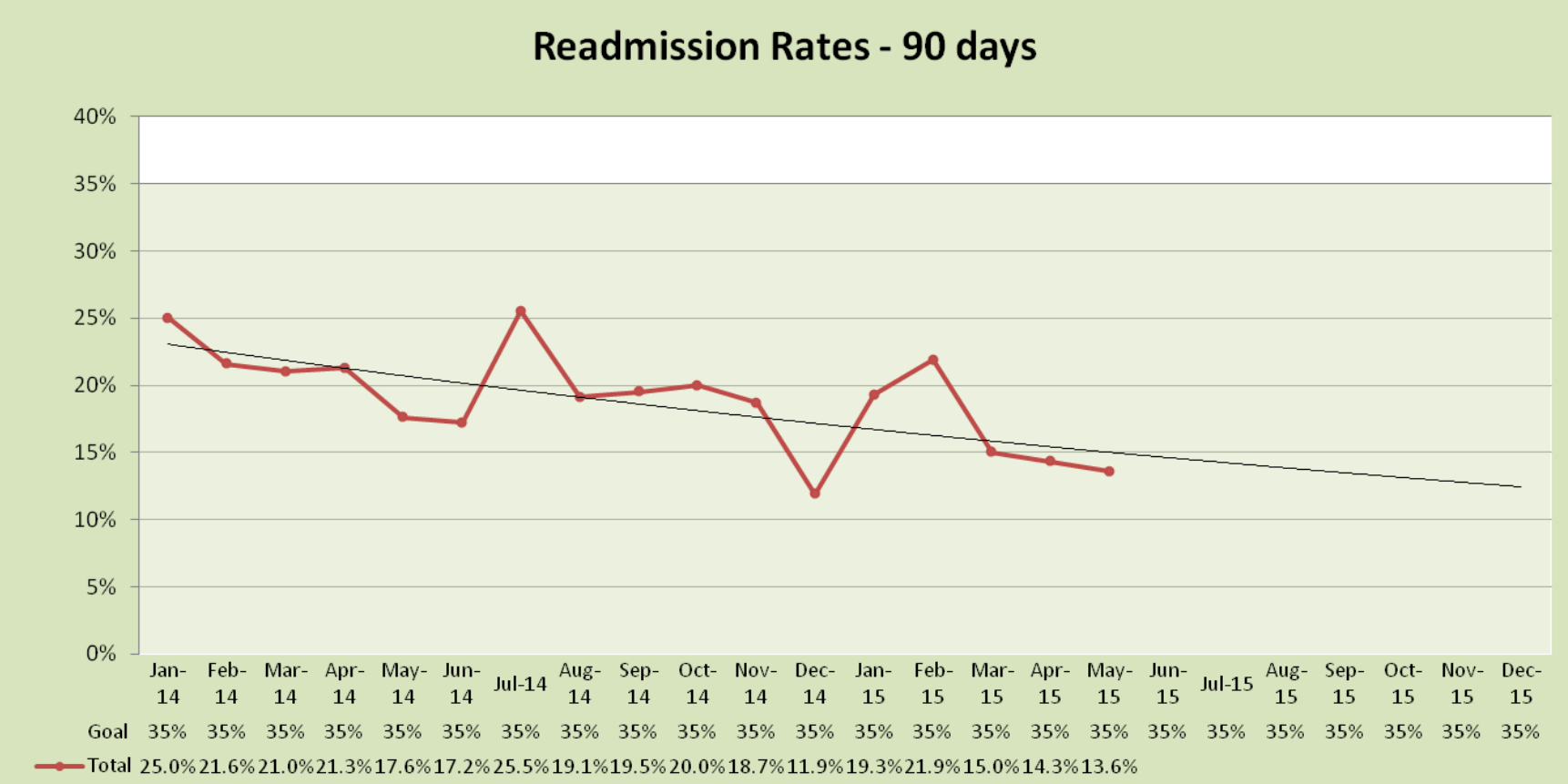
Committee Activity Highlights



4.1.2 Data Source: Enterprise based report - COWO0022A
Data as of 9/10/15

60day MH Readmission Rate: ≤25%
Readmission Rate data is reported on a 3 month lag to capture all updates.

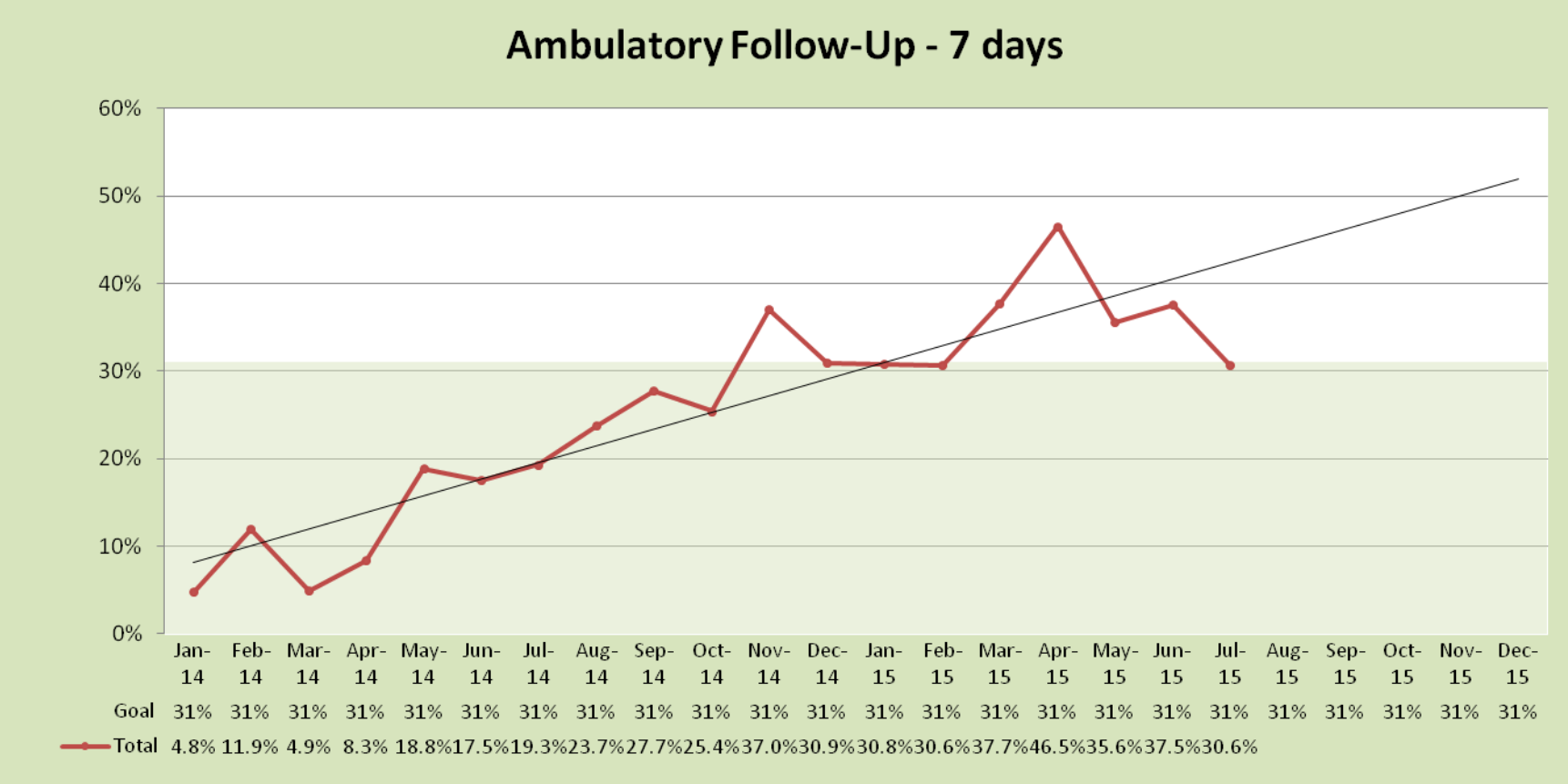
Committee Activity Highlights



4.1.3 Data Source: Enterprise based report - COWO0022A
Data as of 9/10/15

90day MH Readmission Rate: ≤35%
Readmission Rate data is reported on a 4 month lag to capture all updates.

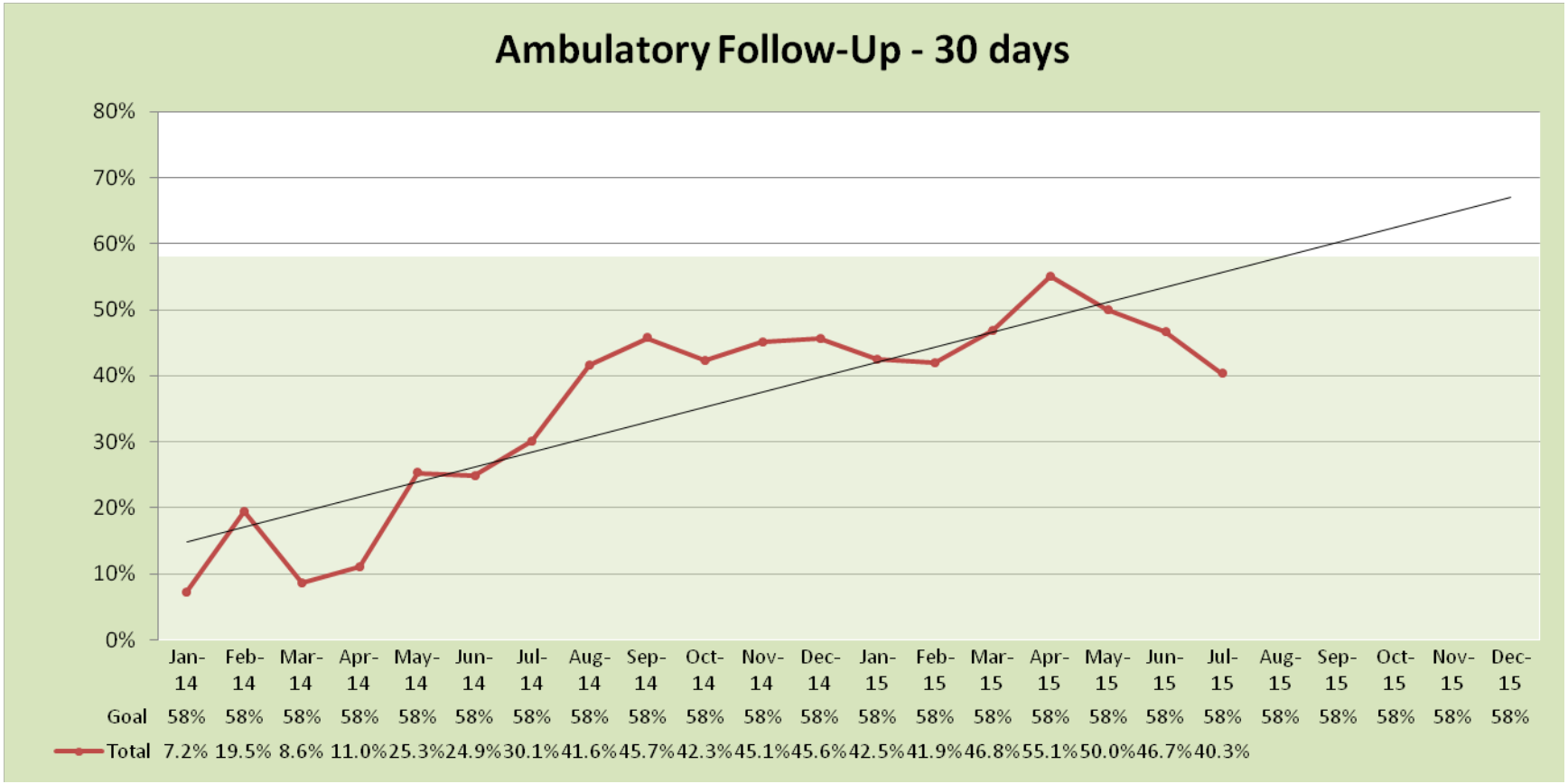
Committee Activity Highlights



4.1.4 Data Source: Enterprise based report – QIWO0028A
Data as of 9/10/15

7 day FAH: ≥31%
7/30-Day Follow-up data is reported on a 2 month lag to capture all updates.
Member adherence to aftercare plan (follow-up treatment) within 7 days of discharge from hospital stay.

Committee Activity Highlights



4.1.5 Data Source: Enterprise based report – QIWO0028A
Data as of 9/10/15

30 day FAH: ≥58%
Member adherence to aftercare plan (follow-up treatment) within 30 days of discharge from hospital stay.

Confidentiality Statement for Providers

The information presented in this presentation is confidential and expected to be used solely in support of the delivery of services to Magellan members. By receipt of this presentation, each recipient agrees that the information contained herein will be kept confidential and that the information will not be photocopied, reproduced, or distributed to or disclosed to others at any time without the prior written consent of Magellan Health, Inc.

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Magellan HEALTH℠

Thanks

NAMI Virginia
National Alliance on Mental Illness

Presentation to
2015 VCOPPA Symposium

NOVEMBER 11, 2015

Needs Assessment: Adult Mental Health System

Top Priorities

1. Expand permanent supportive housing
2. Integrate mental health care with primary health care
3. Strengthen round-the-clock emergency services and stabilization for crises
4. Expand intensive outpatient services
5. Cover the uninsured/Medicaid expansion
6. Improve/ensure acute care access (hospital beds)

Needs Assessment: Child Mental Health System

Top Priorities

1. Implement parent and youth peer support services in the child serving systems
2. Expand the array of services so that there is a true continuum of care for children and youth with mental health needs and their families
3. Expand transition age youth services to every community
4. Bring Systems of Care values and principles to scale in Virginia

Priorities

1. Accountability and Excellence in the Mental Health System
2. Peer Support, Family Support, and System Navigation
3. Criminal Justice
4. Early Intervention Services and Transition-Age Youth
5. Continuum of Care for Children, Youth, and Adults
6. Housing
7. The Uninsured

Thank you

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PRIVATE SCHOOL REGULATIONS

REGULATIONS GOVERNING THE OPERATION OF PRIVATE SCHOOLS FOR STUDENTS WITH DISABILITIES, EFFECTIVE AUGUST 26, 2015

VDOE GUIDANCE ON IMPLEMENTATION OF KEY REQUIREMENTS

PURPOSE

- The primary purpose of this training is for the Virginia Department of Education (VDOE) to review the ***Regulations Governing the Operation of Private Schools for Students with Disabilities***, effective August 26, 2015, and to provide private and public school administrators with guidance on how VDOE will be monitoring compliance with new requirements of these regulations, as well as key areas of repeated noncompliance as seen by the private school monitiors during their licensure reviews.

VDOE RESPONSIBILITIES

- Licensure of Private Schools
- Work collaboratively with private school administration
- Monitor for **substantial** compliance
- Identify strengths and examples of best practice
- Identify areas in need of improvement
  - Private Schools
  - Sending Agencies
- Provide technical assistance
  - Individual schools
  - Collectively as requested/warranted
  - Informing of VDOE training opportunities
- Follow-up on corrective action plan (CAP) Requirements
- Liaison with accrediting agencies
- Liaison with other licensing agencies

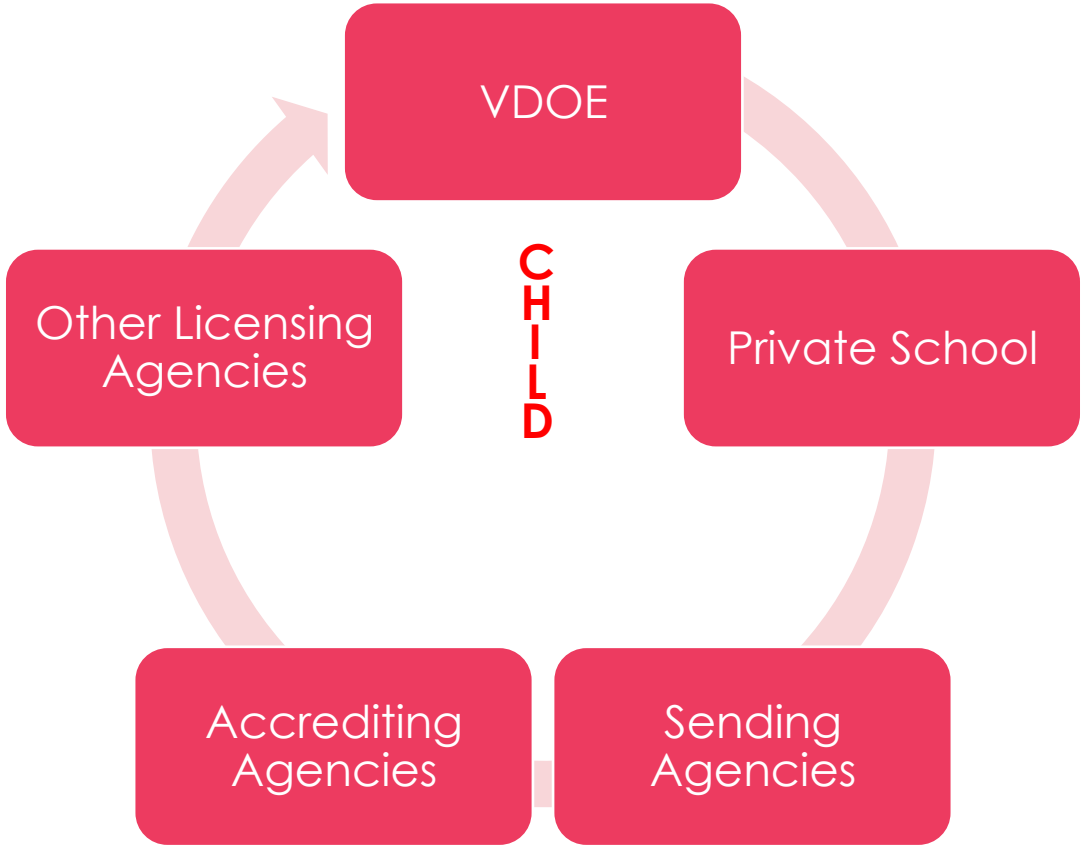
PRIVATE SCHOOL RESPONSIBILITIES

- Adhere to regulatory requirements
- Work collaboratively with VDOE
- Work collaboratively with public schools
  - Prior to accepting child
  - Revising IEPs/504 Plans – reevaluations
  - SOL testing
  - Corrective actions
- Provide appropriate programming
- Independently seek technical assistance
- Stand prepared for a licensing monitoring review at any time
- Take timely corrective actions

PUBLIC SCHOOL RESPONSIBILITIES

- Adhere to regulatory requirements
- Work collaboratively with private schools
  - Prior to enrolling
  - Revising IEPs/504 Plans – reevaluations
  - SOL testing
  - Corrective actions
- Work collaboratively with VDOE
- Ensure children are receiving a free appropriate public education (FAPE)
- Seek technical assistance
- Take timely corrective actions

THE FOCUS IS ALWAYS ON THE CHILD



TYPES OF LICENSE - CONDITIONAL
8VAC20-671-50

- A conditional license may be issued upon approval of an application to operate a school for students with disabilities not to exceed a period of six months. A conditional license may be renewed for a period of six months when a new school demonstrates compliance with administrative and policy requirements but has not fully demonstrated substantial compliance with requirements of this chapter.

8VAC20-671-50.1

- **A six month conditional license will be issued to all schools applying for initial licensure.**

TYPES OF LICENSE – ANNUAL
8VAC20-671-50

- An annual license may be issued under the following conditions and may be extended for a period not to exceed 36 successive months:

a. A school provides notice for continued licensure while holding a conditional or provisional license.

b. When a school holds a provisional license and substantially meets the requirements of this chapter.

c. When a school makes significant changes in its operation.

8VAC20-671-50.2

- A school may receive an annual license for 3 consecutive years (36 successive months) and if not in substantial compliance with the regulation at the end of this period, the license will not be renewed.

TYPES OF LICENSE – TRIENNIAL
8VAC20-671-50

- A triennial license shall be issued when a school holds an annual or triennial license and substantially meets the requirements of this chapter.

8VAC20-671-50.3

TYPES OF LICENSE – PROVISIONAL
8VAC20-671-50

- The term of a school's license may be reduced to provisional when the school has demonstrated an inability to achieve or maintain compliance with this chapter or other applicable regulations.
- a. A provisional license may be issued at any time.
- b. A provisional license may be renewed.
- c. The issuance of a provisional license and any renewal thereof shall be for no longer a period than six successive months.

8VAC20-671-50.1

CHANGE IN CONDITION
8VAC20-671-60

- A condition of a license may be modified during the term of the license with respect to: capacity of the school or classrooms; disability category or categories of students served; age range; grade levels, change in location; change in services; change in ownership; merger of schools; and enrollment of day student(s) in a residential setting.

8VAC20-671-60.A

CHANGE IN CONDITION 8VAC20-671-60 (CONTINUED)

- If a private school accepts and enrolls a child for whom they are not currently licensed, based on any level of disability – primary, secondary, or tertiary, they must request an exemption by submitting a plan to VDOE as to how they will ensure that the child will receive the services outlined in his/her IEP based on the disability categories. VDOE will review the request and provide the school with a letter outlining the approval or denial of the exemption. The exemption, if approved, will be for that student only.
- This is not intended to require that a school amend their license simply because of the exemption status.
- Should a school accept and enroll a second student needing the same exemption within the same school year, then the private school and a VDOE monitoring specialist must discuss whether or not adding that category of licensure is appropriate given the unique circumstances of each situation.

RENEWAL OF LICENSES
8VAC20-671-140

- The license of each school that continues to operate as such shall be renewed on or before the anniversary date set by the department.

- Each license that has not been renewed in accordance with this chapter shall expire.

8VAC20-671-140

- An unannounced licensure review visit will be conducted **no earlier** than 6 months prior to the expiration of a license and **no later** than 3 months preceding the expiration date of the license.

MONITORING
8VAC20-671-150

- The department shall make at least one unannounced visit during the effective dates of the license to operate for the purpose of monitoring the school's compliance with this chapter.

8VAC20-671-150.1

- With regard to the monitoring visit that will directly impact on licensure renewal, the monitoring specialist will notify the private school administrator **of the month** in which the review will occur, no later than the last day of the preceding month.
- The number of unannounced visits during the effective dates of the license will be determined by the schools monitoring specialist and their supervisor based on information and observations collected during any previous visits.
- Monitoring specialist will conduct announced visits when a situation requires the attendance of specific private school personnel.

COMPLAINT RESOLUTION PROCEDURES
8VAC20-671-160

- A complaint may be filed with the department by any individual or organization and shall address an action that occurred not more than one year prior to the date the complaint is received by the department.

8VAC20-671-160

JOB QUALIFICATIONS
8VAC20-671-280

- A person who assumes or is designated to assume the responsibilities of a position or any combination of positions described in this chapter shall meet the qualifications of the position, comply with all applicable regulations for each function, and demonstrate a working knowledge of the policies and procedures applicable to the position.

8VAC20-671-280

JOB QUALIFICATIONS 8VAC20-671-280 (CONTINUED)

- There shall be a written job description for each position that includes job title; duties and responsibilities; job title of the immediate supervisor; and minimum education, experience, kills, and abilities required for entry-level performance of the job.

- A copy of the job description shall be given to each person assigned to a position at the time of employment or assignment.

8VAC20-671-290

SCHOOL ADMINISTRATORS JOB QUALIFICATIONS
8VAC20-671-300

- The licensee shall designate an individual(s) who is a graduate of an accredited college or university and is responsible for the administrative operation of the school. This individual may also serve as the instructional leader. The school administrator shall, in part:

  - ❑ Protect the academic instructional time from unnecessary interruptions;
  - ❑ Involve the school staff in identifying staff development needs to improve student achievement and ensure staff participation;
  - ❑ Analyze classroom practices and methods for improvement of instruction;
  - ❑ Monitor and evaluate the quality of instruction and provide supports as needed to improve instruction.

8VAC20-671-300.A and B.

SCHOOL ADMINISTRATORS JOB QUALIFICATIONS 8VAC20-671-300 (CONTINUED)

- The instructional leader shall hold a valid five-year renewable postgraduate professional license issued by the board with an endorsement in school administration and supervision or special education and have at least three years of experience working with students with disabilities.

8VAC20-671-300.C

- VDOE will review the instructional leader's personnel record for copy of a five-year renewable postgraduate professional license.

SCHOOL ADMINISTRATORS JOB QUALIFICATIONS 8VAC20-671-300 (CONTINUED)

- The instructional leader **or designee** shall at all times be on the premises of the school while the school is in operation.
- All staff on duty must know who is responsible for the administration of the school at any given time

8VAC20-671-300.D and E

TEACHERS AND STAFFING
8VAC20-671-310

- Teacher caseloads shall be assigned in accordance with the Regulations Governing Special Education Programs for Children with Disabilities in Virginia (8VAC20-81).

- 1. If children with disabilities in a single building receive academic content area instruction from multiple special education teachers, the teachers' caseloads shall be determined by using a building average.

- 2. When special education personnel are assigned to provide services for students who do not have a disability under this chapter or are assigned to administrative duties, there shall be a reduction in the caseload specified in proportion to the percentage of school time on such assignment.

- 3. Special education personnel may be assigned to serve children who are not eligible for special education and related services as long as they hold appropriate licenses and endorsements for such assignments.

8VAC20-671-310.D

SUPPORT STAFF
8VAC20-671-330

- Paraprofessionals and other ancillary staff shall be at least 18 years of age (21 years of age preferred), at a minimum hold a high school diploma or General Educational Development (GED) certificate, have two years of work experience with children or completed two years of coursework in a related field, or upon employment complete within 60 calendar days of hire training specific to the assigned student population and job duties as they relate to the academic and behavioral progress of students.

8VAC20-671-330.B

SUPPORT STAFF 8VAC20-671-330 (CONTINUED)

- No support staff shall be used as replacement for teachers or related service staff unless they meet the qualifications of the position.

8VAC20-671-330.C

- Support staff who do not meet licensure or certification requirements shall not be given misleading work titles or titles that infer they meet required credentials.

8VAC20-671-330.D

Terms such as educational therapist, behavior specialist, therapeutic counselor, and mental health counselors are examples of misleading titles if given to staff that do not hold a professional license or certificate._

SUPPORT STAFF 8VAC20-671-330 (CONTINUED)

- Paraprofessionals shall work under the supervision of qualified professional staff.

8VAC20-671-330.E

Paraprofessionals must be under the direct supervision of a licensed teacher. While a paraprofessional may provide instructional support, all lesson planning must be completed by the licensed teacher.

STAFF DEVELOPMENT
8VAC20-671-350

- *In addition to initial orientation, staff need to have their skills and knowledge reinforced and expanded so that they can maintain a high level of quality in the care of the students. Staff training includes work-site lectures, demonstration, seminars, on-line learning etc. as well as off-site activities such as college courses and professional meetings.*

- Each staff who works directly with students shall annually receive 15 hours of professional development related to student progress and academic achievement that is applicable to the population served and to their job duties.

8VAC20-671-350.G

- Monitoring specialist will be looking for a training calendar reflecting a schools planned training/professional development activities.
- Monitoring specialists will also be looking for documentation in each employee's personnel file that the required trainings have been completed.

SCHOOL FACILITIES AND SAFETY
8VAC20-671-370

- Each school shall provide safe and adequate instructional areas, space for administrative staff, pupil personnel services, library and media services, and physical education. Schools established after the effective date of these regulations and classrooms added to existing buildings shall provide at least 50 square feet of classroom or instructional area per student excluding classroom fixtures.

8VAC20-671-370.C

CONTINGENCY PLANS
8VAC20-671-380

- The school shall have a written emergency preparedness and response plan for all locations.

8VAC20-671-380.D

STUDENT APPLICATION AND ADMISSION
8VAC20-671-410

- Each school's admissions process shall be designed to determine the suitability of enrolling a student. The school shall accept and serve only those students whose needs are compatible with the services provided by the school.

8VAC20-671-410.C

- When the student's education records are not provided during the application process, the school with written parental consent shall make a request within five business days of enrollment to the student's last attended school or the division superintendent or designee.

8VAC20-671-410.E

STANDARD SCHOOL YEAR AND SCHOOL DAY
8VAC20-671-420

- Each school shall have a standard school year of at least 180 teaching days or a total of at least 990 teaching hours per year. The standard school day for students in grades 1 through 12 shall average at least five and one-half teaching hours or average 27 and one-half hours weekly, excluding breaks for meals and recess, and a minimum of three instructional hours daily for kindergarten.

8VAC20-671-420.A

- The private school shall initiate a team meeting to review the child's IEP, 504 Plan, or IIP when a student has a medical, mental, or physical condition that requires modification of the student's school schedule.

8VAC20-671-420.B

STUDENT ACHIEVEMENT EXPECTATIONS
8VAC20-671-450

- Participation in the Virginia assessment program by students with disabilities shall be prescribed by provisions of their IEPs or 504 Plans.

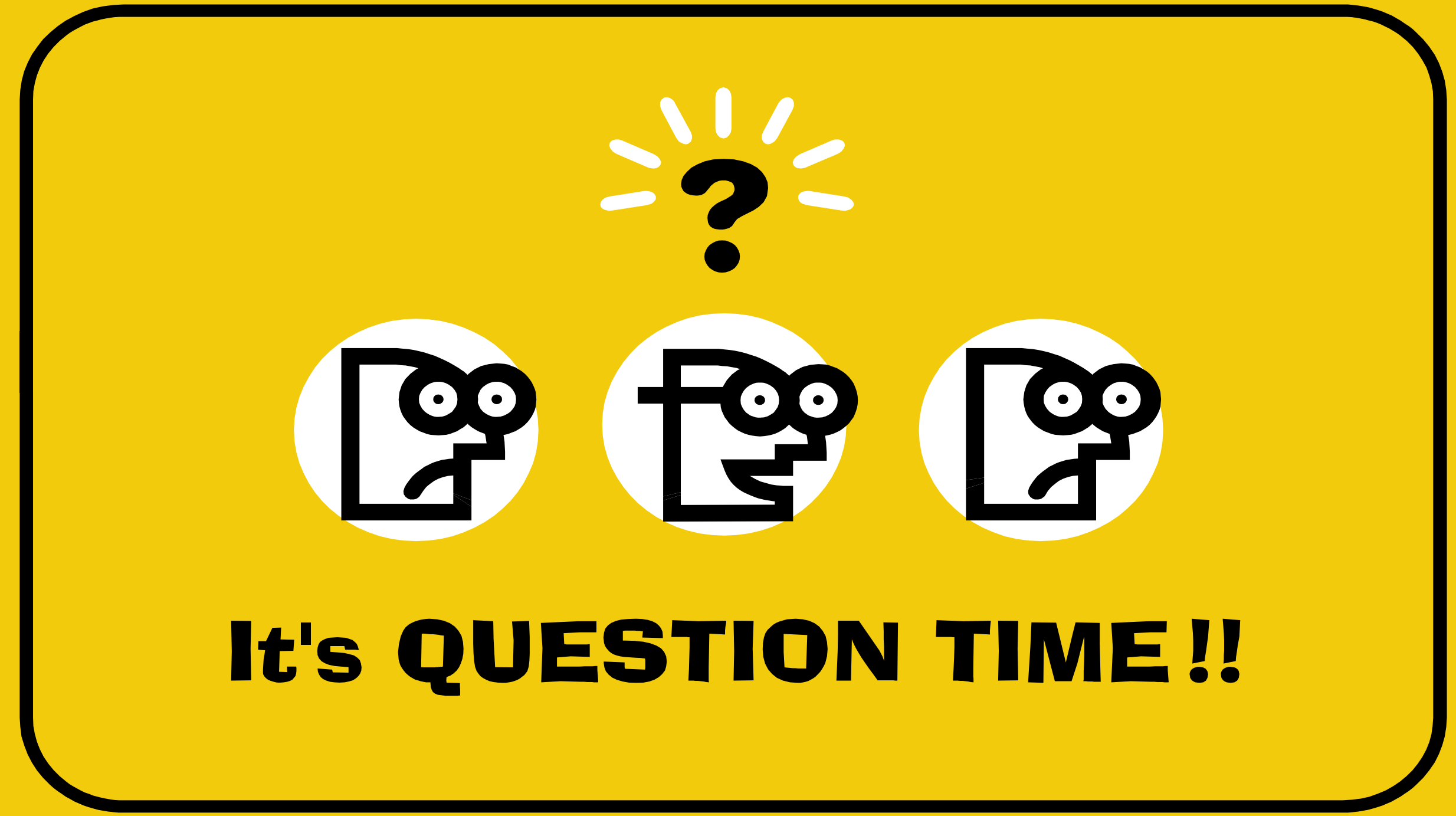
8VAC20-671-450.B

- Each school that serves students who anticipate earning a diploma and graduating from a public Virginia high school must follow the requirements for graduation outlined in the Regulations Establishing Standards for Accrediting Public Schools in Virginia (8VAC20-131).

8VAC20-671-450.C

- The school shall cooperate with the public school in the administration of SOL tests.

8VAC20-671-450.D


It's QUESTION TIME!!

INDIVIDUALIZED EDUCATION PROGRAM (IEP)
8VAC20-671-460

- A representative of the private school shall attend IEP meetings upon the request of the student's school division. If a representative is not able to attend, the school shall use other methods to ensure participation including individual or conference telephone calls.

8VAC20-671-460.A

- Any meetings to review and revise the child's IEP may be initiated and conducted by the private school at the discretion of the student's school division.

8VAC20-671-460.B

INDIVIDUALIZED EDUCATION PROGRAM (IEP) 8VAC20-671-460 (CONTINUED)

- If the private school initiates and conducts these meetings, the student's school division and the parent(s) shall:
  - Be involved in any decision affecting the child's IEP;
  - Agree to any proposed changes in the program before those changes are implemented; and
  - Be involved in any meetings that are held regarding reevaluation.

8VAC20-671-460.C

INDIVIDUALIZED EDUCATION PROGRAM (IEP) 8VAC20-671-460 (CONTINUED)

- A parent does not include local or state agencies or their agents, including local departments of social services, if the child is in the custody of such an agency.

8VAC20-671-460.D

- When a child with a disability is placed by a local school division or family assessment and planning team in a private school, all rights and protections under state and federal regulations shall be extended to the child.

8VAC20-671-460.D

INDIVIDUALIZED INSTRUCTION PROGRAM (IIP)
8VAC20-671-470

- The IIP shall provide a beginning and ending date of services.

8VAC20-671-470.C

- The IIP shall be reviewed at least annually by a team that includes the school administrator or teacher, other staff as appropriate, parent, and student as appropriate.

8VAC20-671-470.D

- Student progress reports shall be provided to the parent at least quarterly

8VAC20-671-470.E

504 PLANS
8VAC20-671-480

- Each school admitting students with 504 Plans shall implement the plan and cooperate with the school division in its annual review. An individualized instruction plan (IIP) shall be developed for each student with a 504 plan.

PROGRAM OF INSTRUCTION AND LEARNING OBJECTIVES
8VAC20-671-490

- The instructional program shall be designed to meet the needs of all students enrolled and shall educate students with age-appropriate peers unless it can be shown that for a particular child with a disability, the alternative placement is appropriate and documented on the student's IEP, IIP, or 504 Plan.

8VAC20-671-490.B

PROGRAM OF INSTRUCTION AND LEARNING OBJECTIVES
8VAC20-671-490 (CONTINUED)

- Services shall be delivered in accordance with the student's IEP, IIP, or 504 Plan.

8VAC20-671-490.C

- Children of preschool ages (two years to five years, inclusive) shall receive services determined by the child's IEP, IIP, or 504 Plan.

8VAC20-671-490.D

PROGRAM OF INSTRUCTION AND LEARNING OBJECTIVES 8VAC20-671-490 (CONTINUED)

- Students 14 years of age and older shall be provided opportunities to gain knowledge and, training, employment, and independent living, as appropriate.

8VAC20-671-490.E

PROGRAM OF INSTRUCTION AND LEARNING OBJECTIVES 8VAC20-671-490 (CONTINUED)

- Each school shall require students to participate in a program of health and physical fitness during the regular school year unless the student is unable to participate due to a medical condition or has met the credit requirement for graduation.

8VAC20-671-490.G

PROGRAM OF INSTRUCTION AND LEARNING OBJECTIVES 8VAC20-671-490 (CONTINUED)

- Each school shall provide students with opportunities to gain appreciation for art and music.

8VAC20-671-490.H

- Each school shall implement evidence-based practices to improve academic, behavior, and social outcomes for all students.

8VAC20-671-490.K

INSTRUCTIONAL PROGRAM FOR MIDDLE SCHOOL GRADES
8VAC20-671-510

- Each school shall ensure that students who are unable to read with comprehension the materials used for instruction receive additional instruction in reading.

8VAC20-671-510.2

- Each school shall provide students with opportunities for career and technical exploration.

8VAC20-671-510.3

INSTRUCTIONAL PROGRAM FOR SECONDARY SCHOOL GRADES
8VAC20-671-520

- Each school shall ensure that students who are unable to read with comprehension the materials used for instruction receive additional instruction in reading.

8VAC20-671-520.6

- Staff shall provide guidance and counseling to assist students in meeting graduation requirements.

8VAC20-671-520.7

ALTERNATIVE EDUCATION
8VAC20-671-530

- Schools may provide students, 16 years of age to 18 years of age who choose to prepare for the Tests of General Educational Development (GED) certificate, an Individualized Student Alternative Education Plan (ISAEP) program. Implementation of the ISAEP program requires submission of an application and approval by the department.

ALTERNATIVE EDUCATION 8VAC20-671-530 (CONTINUED)

- Requirements for enrollment in the ISAEP program

  - ❑ Initial Principal-Parent Student (PPS) meeting
  - ❑ Student evaluation /assessment
  - ❑ 7.5 grade equivalent or higher on a recognized standardized measure of reading achievement
  - ❑ Achieve a passing score on each of the subtests of the GED Ready Official Practice Test.

    GED Ready Web site -- http://www.gedtestingservice.com/educators/gedready

- Completion Requirements

  - ❑ Passing the GED test
  - ❑ Successful completion of the career and technical component.
  - ❑ Complete an Economics and Personal Finance course

    http://www.doe.virginia.gov/instruction/isaep/index.shtml

TRANSITION SERVICES
8VAC20-671-540

- Schools shall cooperate with the public schools to ensure that the transition plan for each student with a disability, beginning at 14 years of age (or younger), is implemented according to the child's IEP.

8VAC20-671-540.A

- Schools shall provide evidence of transition services designed within an outcome-oriented process for all students, as appropriate, that promotes movement from the private school to a public school the child would normally attend; movement from school to post-school activities, including postsecondary education, vocational training, integrated employment (including supported employment), continuing and adult education, adult services, independent living, or community participation.

8VAC20-671-540.A

FAMILY LIFE
8VAC2-671-560

- Schools may use the Standards of Learning for the family life education program or other education program, that is designed to promote parental involvement, foster positive self-concepts, and provide mechanisms for coping with peer pressure and the stresses of modern living according to the student's developmental stage and has the goal of reducing the incidence of pregnancy and sexually transmitted diseases and substance abuse.

8VAC20-671-560.A

- Schools offering family life shall obtain written consent from the parent for the child's participation.

8VAC20-671-560.B

STUDENT WORK-STUDY OR ON-THE-JOB TRAINING
8VAC20-671-570

- Each school that places students on work-study, on-the-job training or any other form of employment shall ensure compliance with the applicable laws governing the employment of children.

8VAC20-671-570.A

- Work assignments or employment, including rates of pay, shall be approved by the school administrator with the consent of the parent.

8VAC20-671-570.B

- **The purpose of this regulation is to ensure that the work and pay of students comply with any applicable laws governing wages, and hours and any laws governing labor and employment of children, such as current minimum wages, work permits and type of employment permitted. Call the Department of Labor and Industry for questions regarding fair rates of pay.**

VIRTUAL LEARNING
8VAC20-671-580

- Virtual courses may only be offered through accredited providers as outlined in §§ 22.1-212.23 and 22.1-253.13:3 of the Code of Virginia.

8VAC20-671-580.A

- The virtual learning shall be proctored by a licensed teacher or appropriately trained paraprofessional who is supervised by a licensed teacher. The teacher or paraprofessional shall be available to the student.

8VAC20-671-580.B

MANAGING STUDENT BEHAVIOR IN EMERGENCY SITUATIONS
8VAC20-671-660

- Physical restraint or seclusion is allowed only in an emergency situation and only when it is necessary to protect the student or another person from imminent danger of serious physical harm after less intrusive interventions have been attempted and failed to manage that particular behavior and there is a substantial explanation for why other interventions were deemed inadequate or inappropriate.

8VAC20-671-660.B

MANAGING STUDENT BEHAVIOR IN EMERGENCY SITUATIONS 8VAC20-671-660 (CONTINUED)

- Schools shall collect and annually report to the department the number of times restraint and seclusion were used during the school year. The data shall be disaggregated by students and number of occurrences.

8VAC20-671-660.B.11

SUSPECTED CHILD ABUSE AND NEGLECT
8VAC20-671-690

- Reporting immediately, but under no circumstance later than 24 hours after having a suspicion of a reportable offense of child abuse and neglect to the child protective services unit of the local department of social services of the county or city wherein the abuse or neglect was believed to have occurred or to the Department of Social Services toll-free child abuse and neglect hotline and for cooperating with the unit during any investigation.

8VAC20-671-690.A.2

- Any case of suspected child abuse or neglect occurring at the school or on a school-sponsored event or excursion shall be reported immediately to the student's parent and the department. For publically placed students, the home school division and the placing agency shall also be notified.

8VAC20-671-690.A.2

MEDICATION AND HEALTH
8VAC20-671-710

- All medications shall be accepted only in the original container with written permission signed and dated by the parent to administer to the child. The use of all prescriptive medication must be authorized in writing by a licensed prescriber.

8VAC20-671-710.E

- The telephone number of a regional poison control center and other emergency numbers shall be posted on or near the phone.

8VAC20-671-710.I

MEDICATION AND HEALTH
8VAC20-671-710 (CONTINUED)

- All staff responsible for medication administration shall have successfully completed medication training, including refresher training, in a program approved by the Board of Nursing or be licensed by the Commonwealth of Virginia to administer medication before they can administer medication.

8VAC20-671-710.J.1

- Training shall be provided to staff in medication procedures and effects and infection control measures, including the use of standard precautions.

8VAC20-671-710.J.2

MEDICATION AND HEALTH
8VAC20-671-710 (CONTINUED)

- Staff certified in first aid and CPR shall be available at all times on the school grounds and during any school-sponsored activity.

8VAC20-671-710.J.3

- Documentation of medication training must be maintained in personnel files.

8VAC20-671-710.J.4

- Staff authorized to administer medication shall be informed of any known side effects of the medication and the symptoms of the effects.

8VAC20-671-710.J.5

MEDICATION AND HEALTH
8VAC20-671-710 (CONTINUED)

- Upon receiving any medication, staff members handling medication shall count individual tablets and measure the level of liquid medicine in the presence of the parent(s) or another staff member and record the count on the medication log.

8VAC20-671-710.K.1

- The medication log shall include the signature or initials of the staff member who counted the medication and the parent or staff who witnessed the occurrence. When initials are used, the medication administration record must contain the full name of the staff with corresponding initials for identification purposes.

8VAC20-671-710.K.2

MEDICATION AND HEALTH 8VAC20-671-710 (CONTINUED)

- Monitoring specialist will review the medication administration record (MARS) to verify compliance on these regulatory provisions

- Students shall be prohibited from transporting medication unless directed otherwise by the student's health care plan.

8VAC20-671-710.K.3

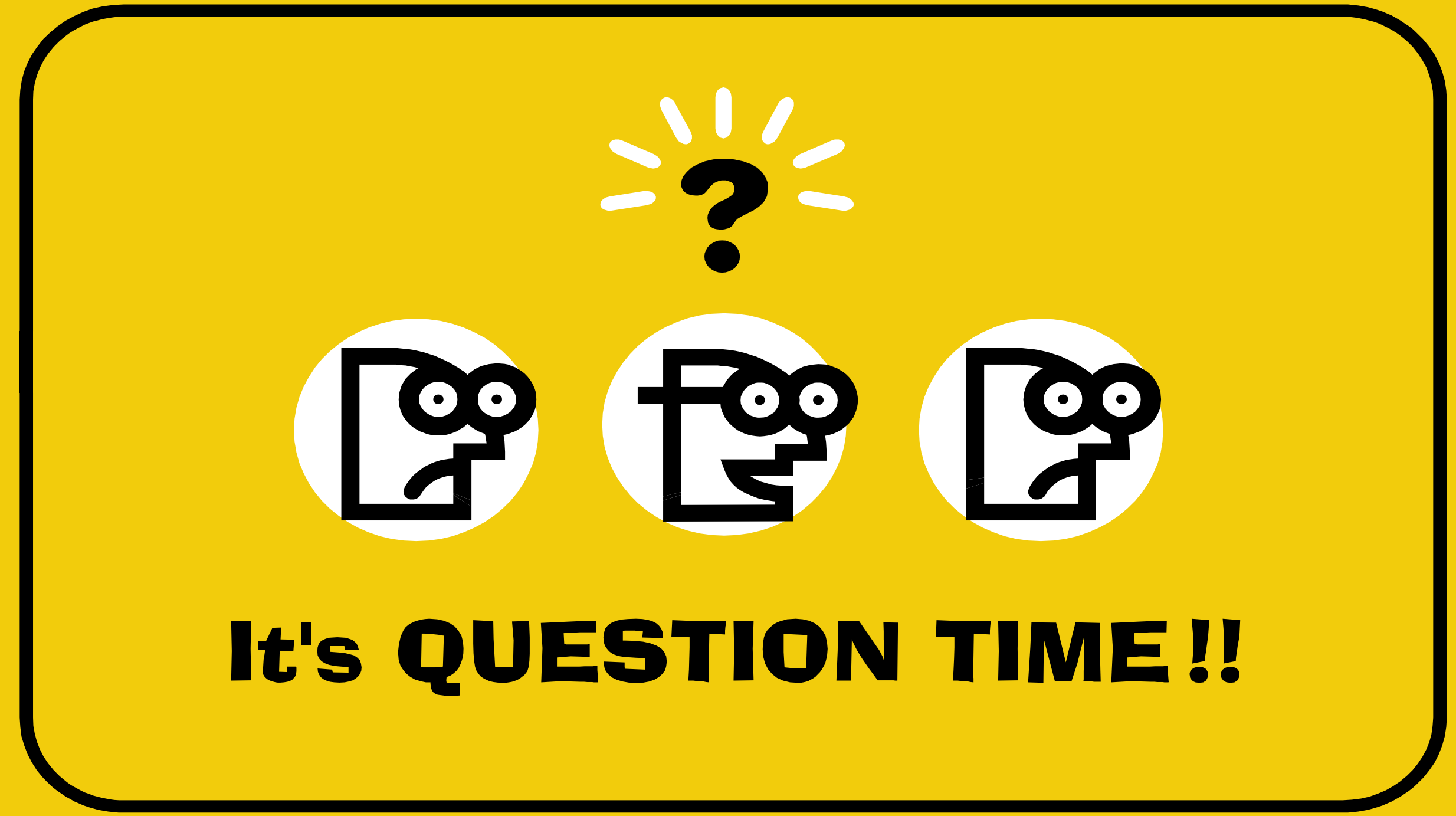
TRANSPORTATION 8VAC20-671-730.

- Monitoring specialist will be checking to see if the school is using any 15 passenger vehicles which they have been advised not to use.

MAINTENANCE OF STUDENT RECORDS
8VAC20-671-760.

- Each school shall maintain a permanent record of attendance to include the following:
  - ❑ Name and address of school;
  - ❑ Name, address, and birth date of student;
  - ❑ Name and address of the home school division for publically placed students;
  - ❑ Name and address of the parent;
  - ❑ Student ID number;
  - ❑ Dates of attendance; and
  - ❑ Academic transcript.

8VAC20-671-760.L


It's QUESTION TIME!!

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Residential Treatment Services Overview and RTC Regulations Project

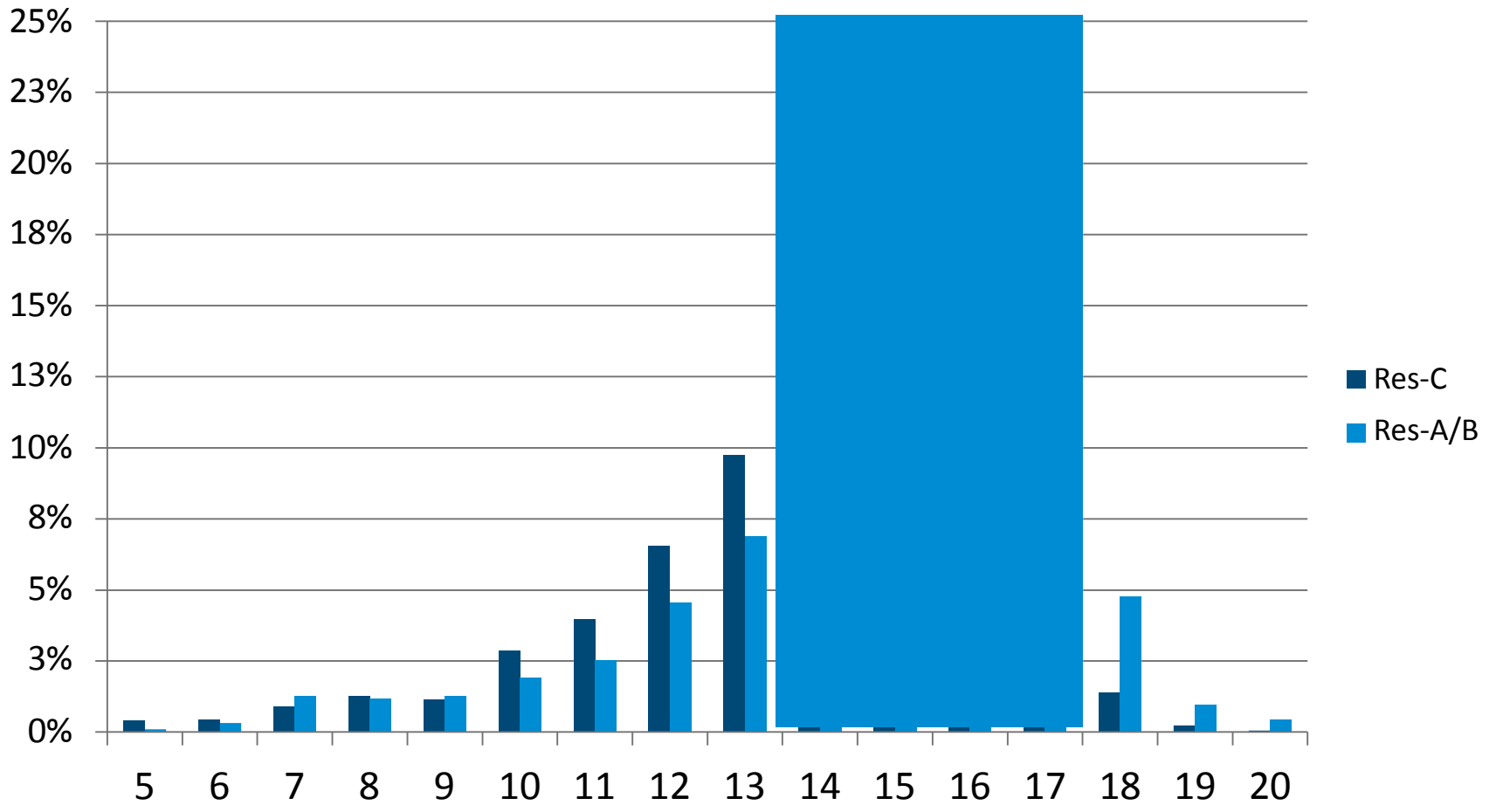
VCOPPA Conference

November 12, 2015

Current Residential Program Data

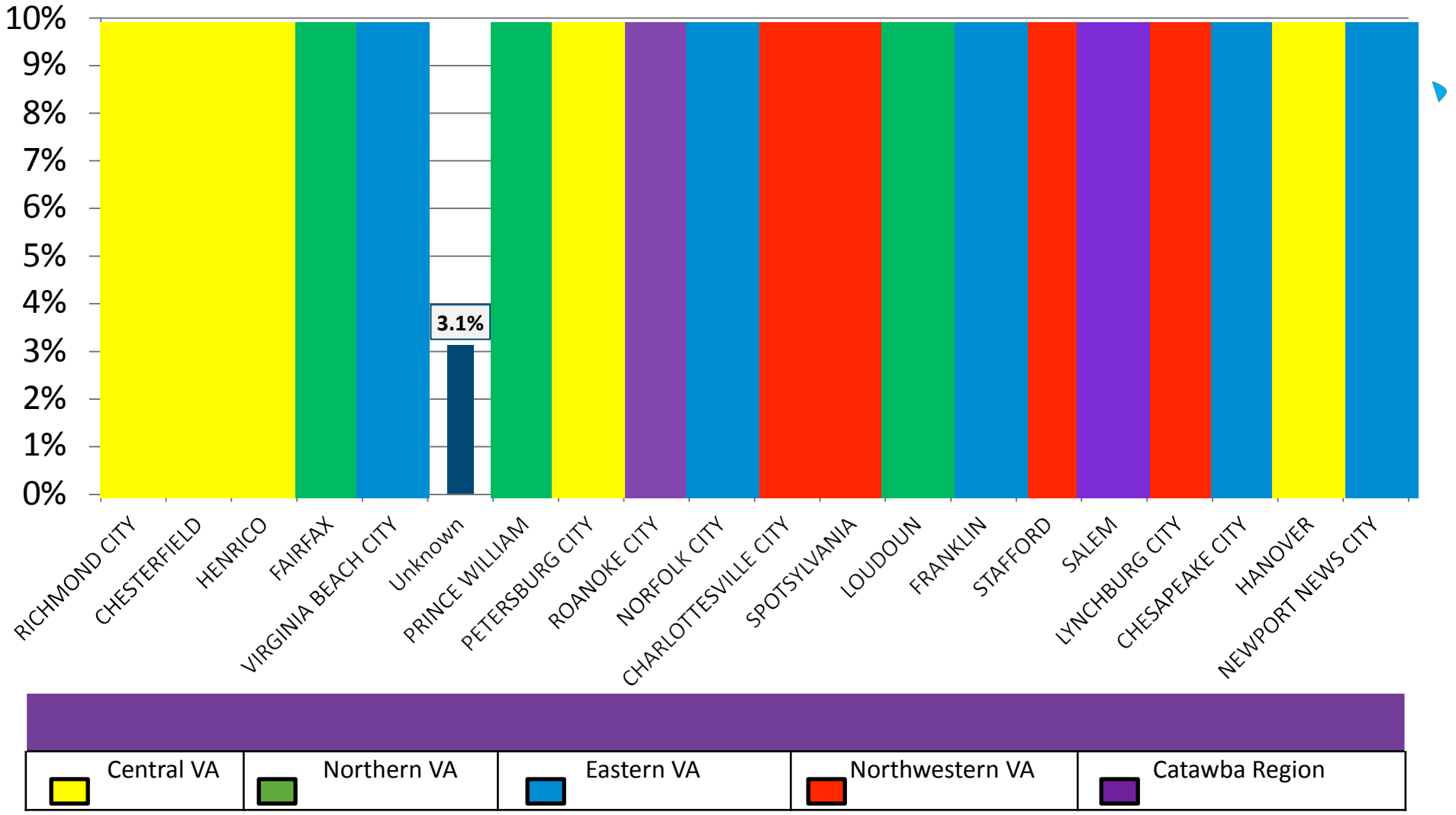
- The following slides are a summary of residential services authorized by Magellan

Age of Member at Residential Services Admission by Percent



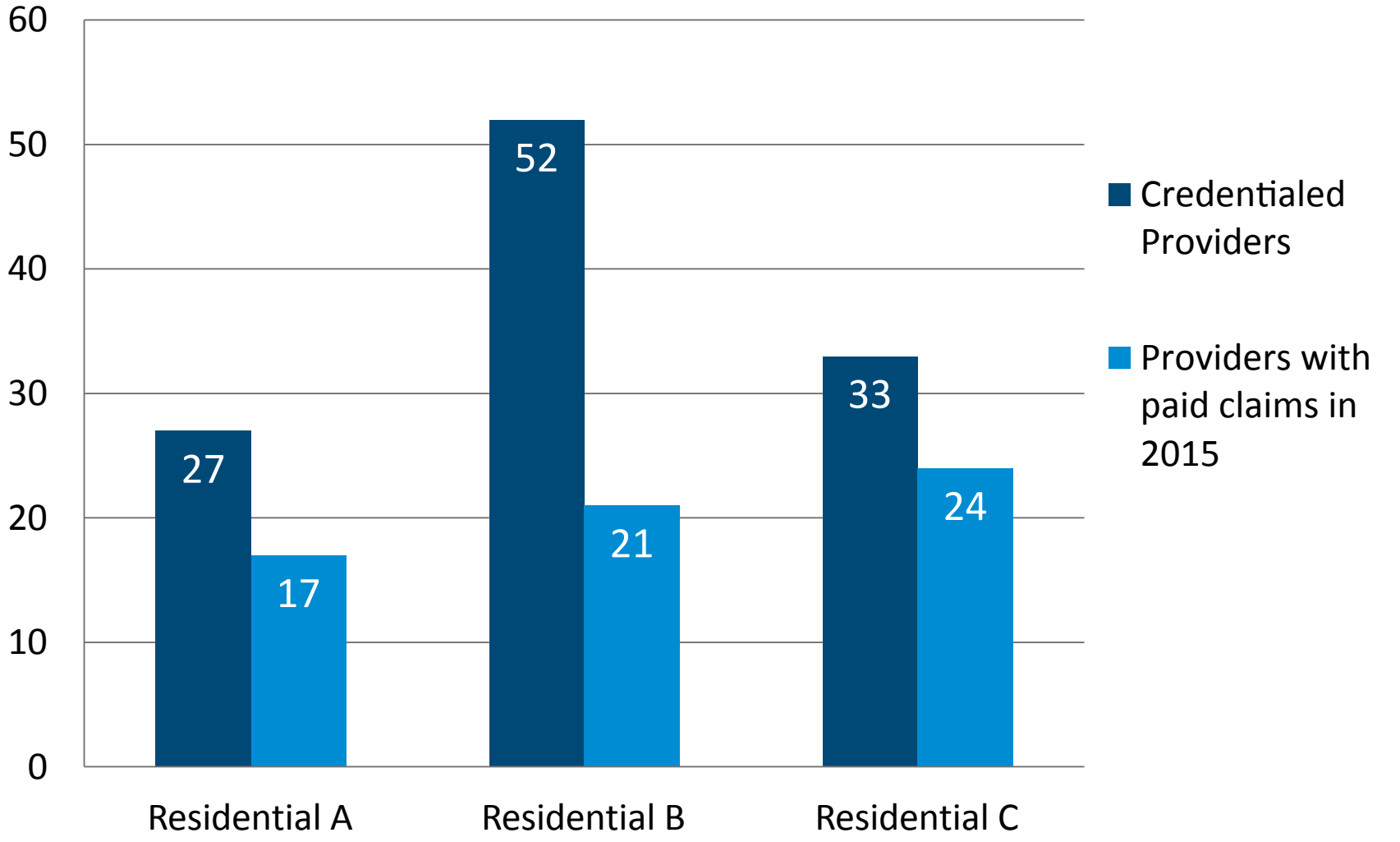
- *Age 5-9 at admission: 4.2%*
- *Age 10-13 at admission: 20.6%*
- *Age 14-17 at admission: 72%*
- *Age 18-20 at admission: 3.2%*

Percentage of Residential Authorizations by Top 20 Member Counties



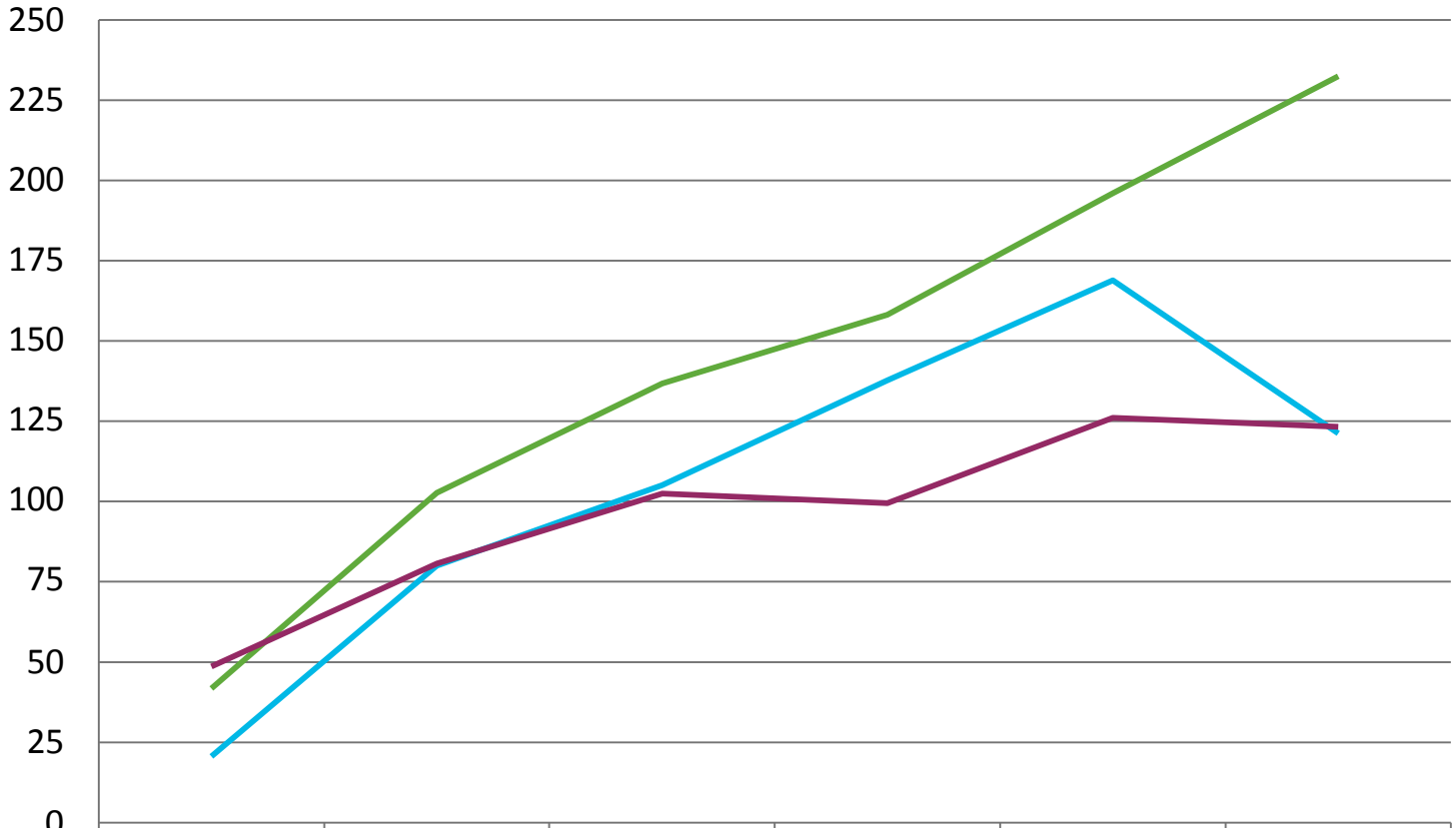
 Data Source: Ad hoc Query: Residential authorization IP data run 9/15/15

Number of Credentialed Residential Providers



Data Sources: IPD data run 9/15/15; Claims report

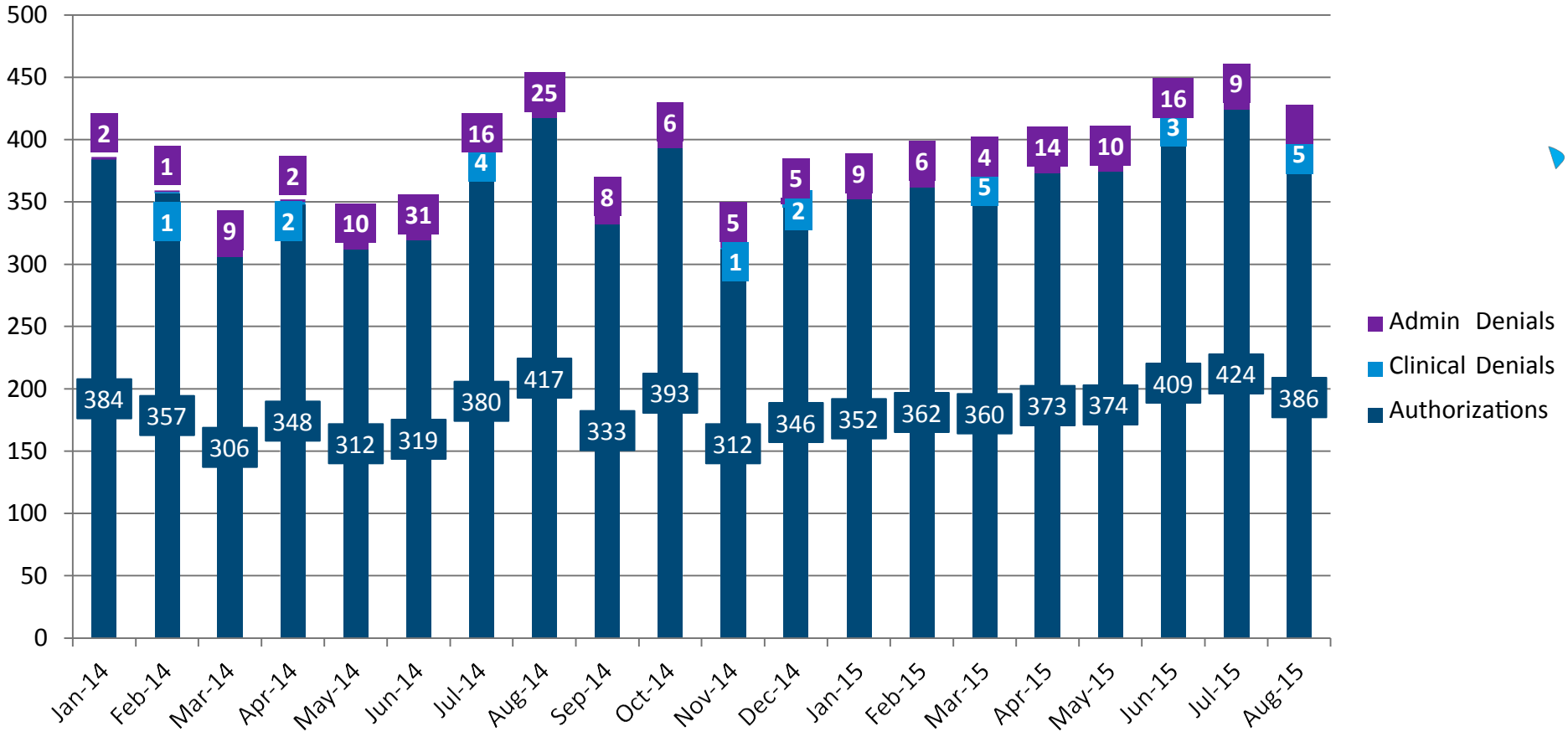
Average Length of Stay for Residential Services by Quarter



	2014 Q1	2014 Q2	2014 Q3	2014 Q4	2015 Q1	2015 Q2
Residential C	41.78	102.68	136.8	158.14	196.05	232.464
Residential A-CSA	20.57	80.05	105.1	137.81	168.92	121.231
Residential B-CSA	48.65	80.68	102.54	99.55	126.08	123.346

Data Source: VA DMAS Custom Utilization Management Report
Non CSA Residential A and Non CSA Residential B data were insubstantial for inclusion in this chart

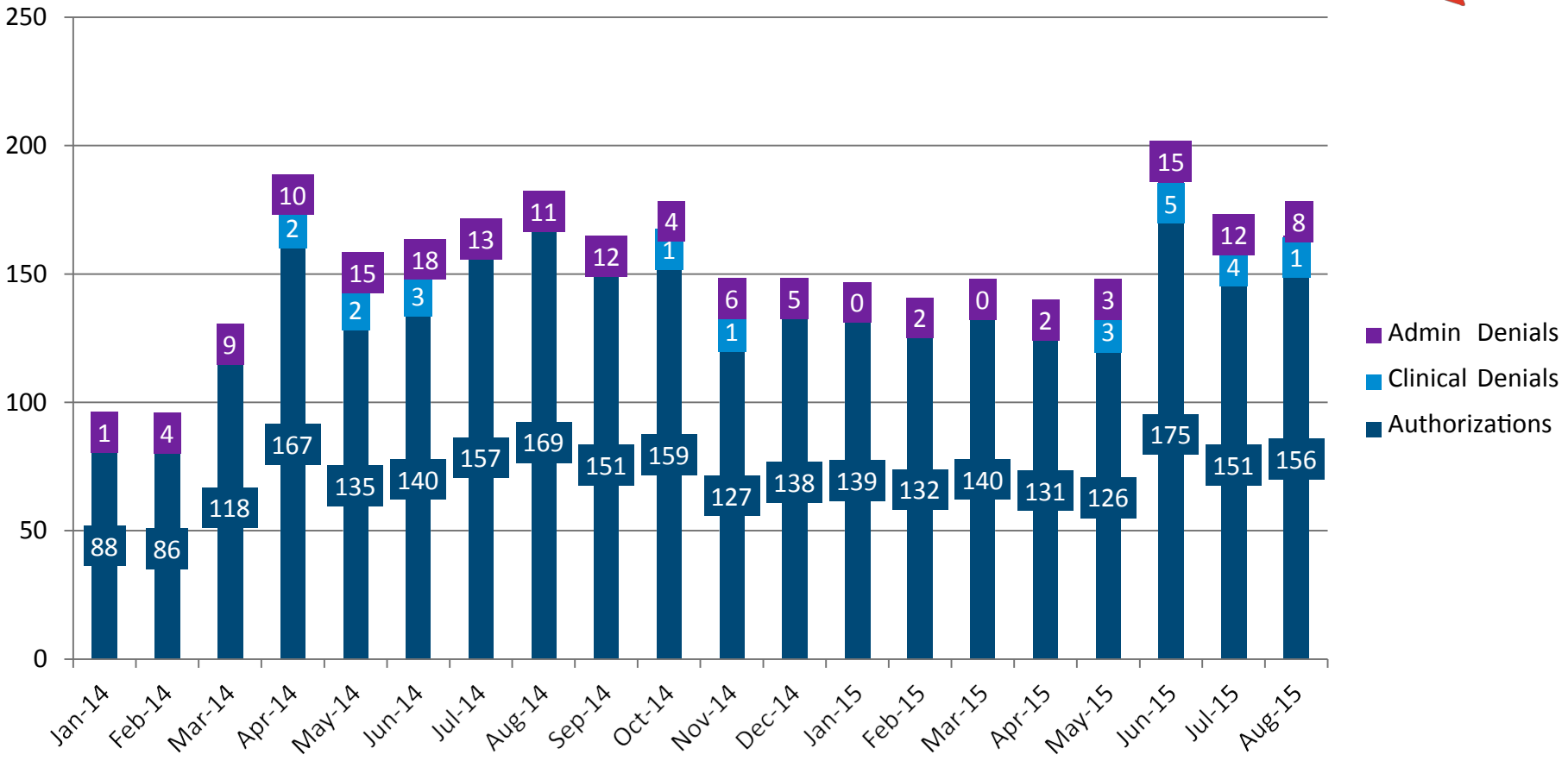
Residential C Authorizations and Denials by Month



2014	2015 YTD
% Authorizations: 97.0%	% Authorizations: 97.2%
% Admin denials: 2.8%	% Admin denials: 2.4%
% Clinical denials: 0.2%	% Clinical denials: 0.4%

 Data Source: Ad hoc Query: Residential authorization IP data run 9/15/15

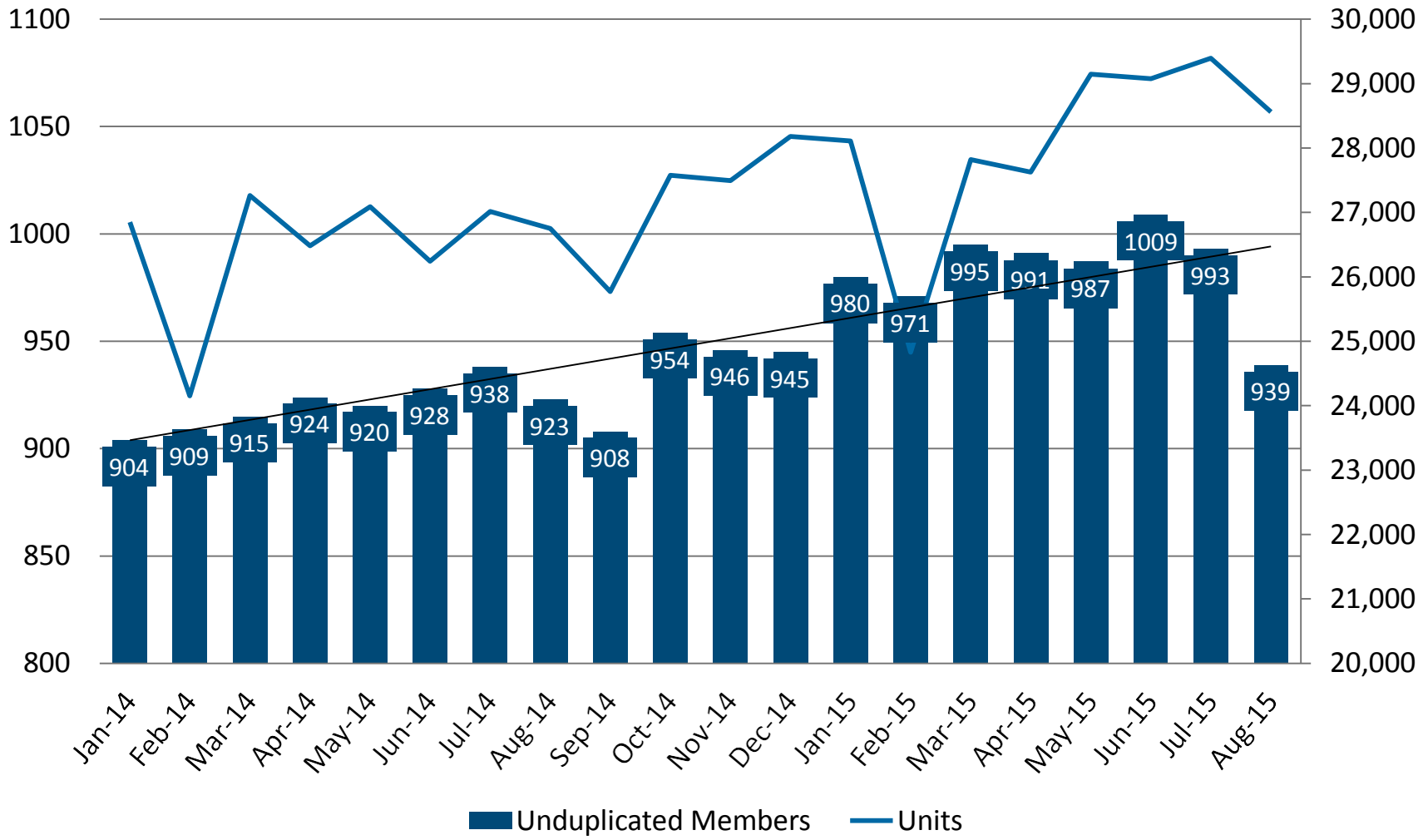
Residential A/B Authorizations and Denials by Month



2014	2015 YTD
% Authorizations: 93.3%	% Authorizations: 95.4%
% Admin denials: 6.2%	% Admin denials: 3.5%
% Clinical denials: 0.5%	% Clinical denials: 1.1%

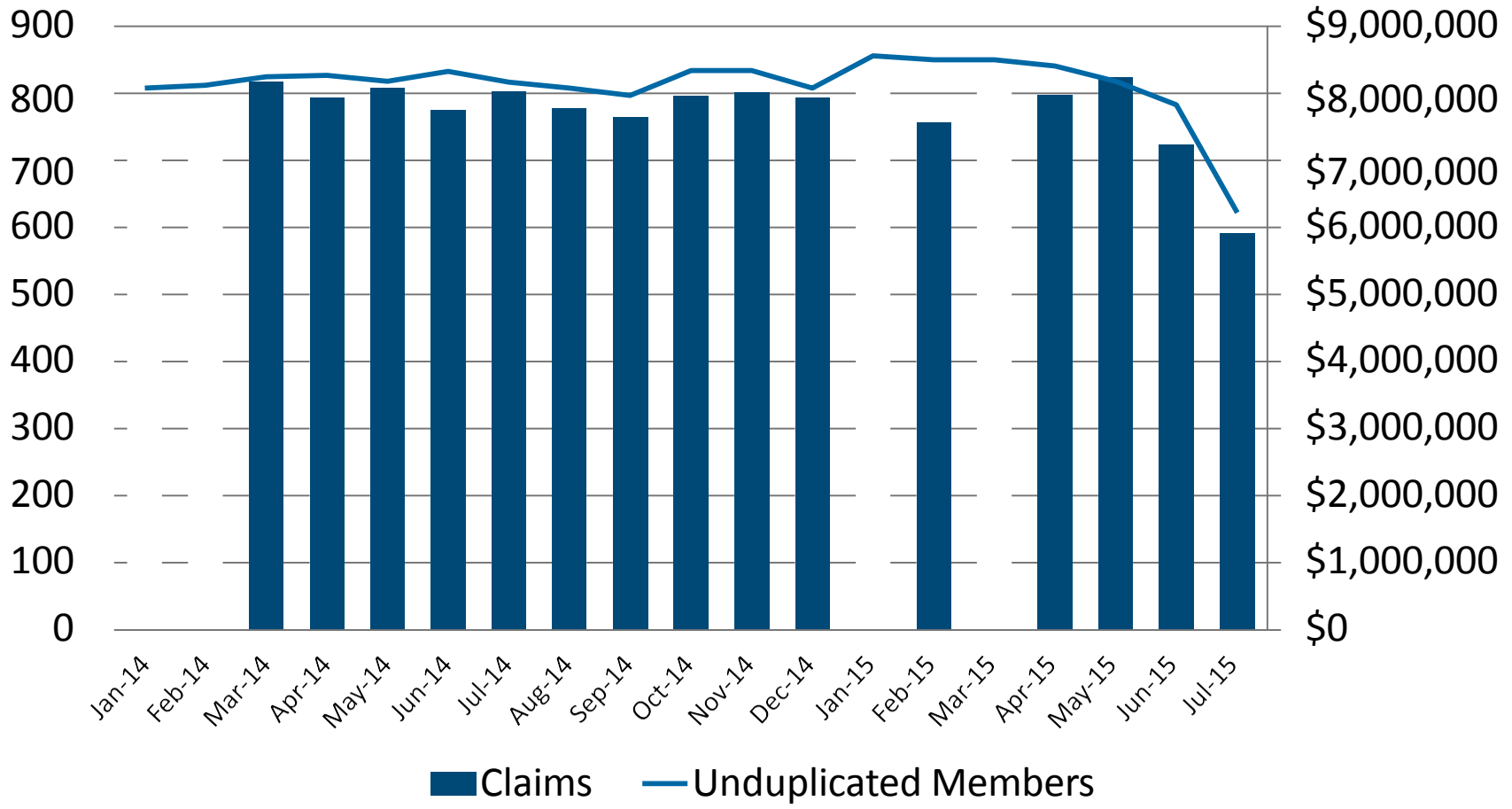
 Data Source: Ad hoc Query: Residential authorization IP data run 9/15/15

Residential C: Unduplicated Members and Authorized Units by Month



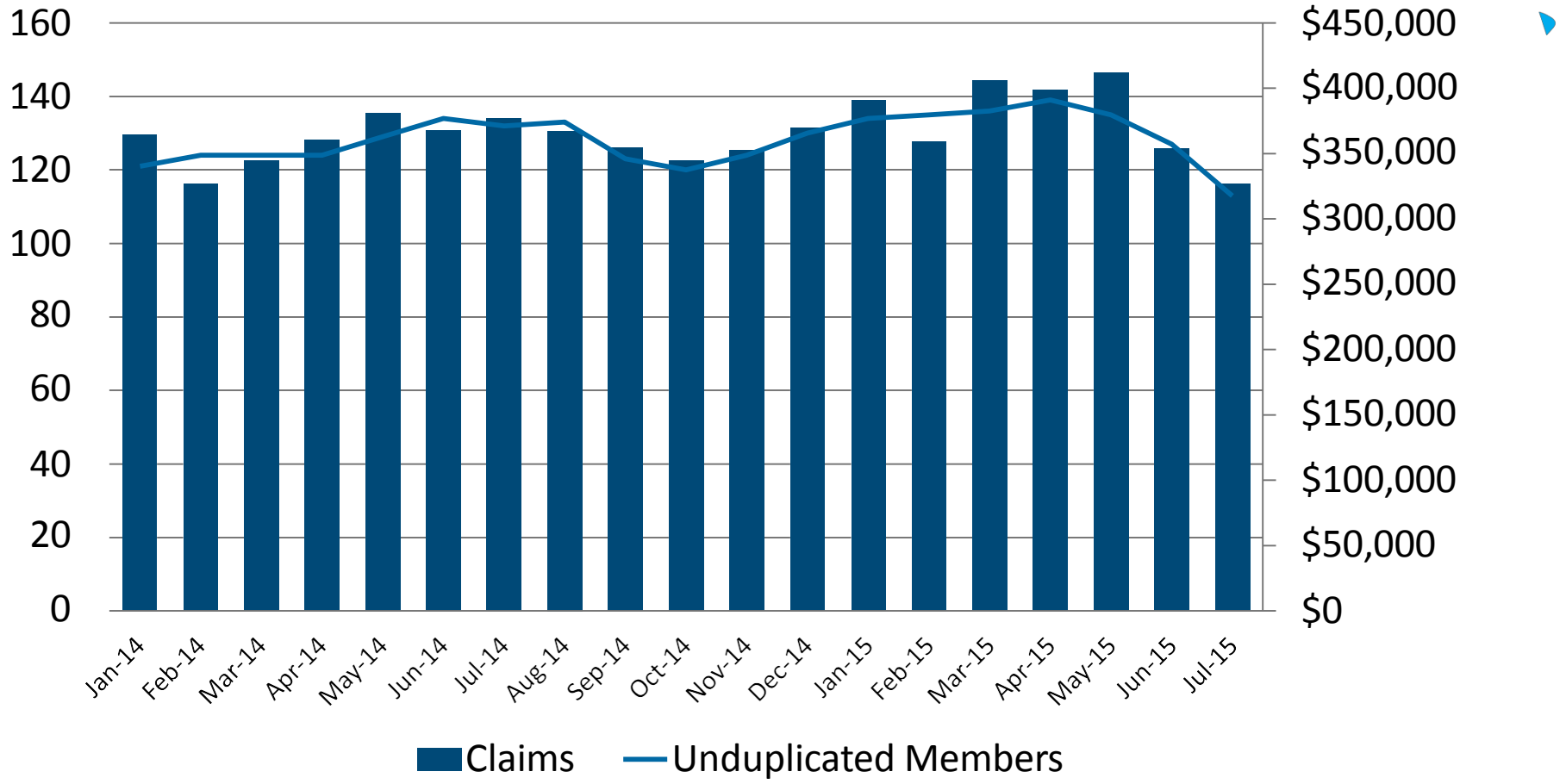
 Data Source: VAD_Auths_ Monthly Summary

Residential C: Claims paid by Unduplicated Member



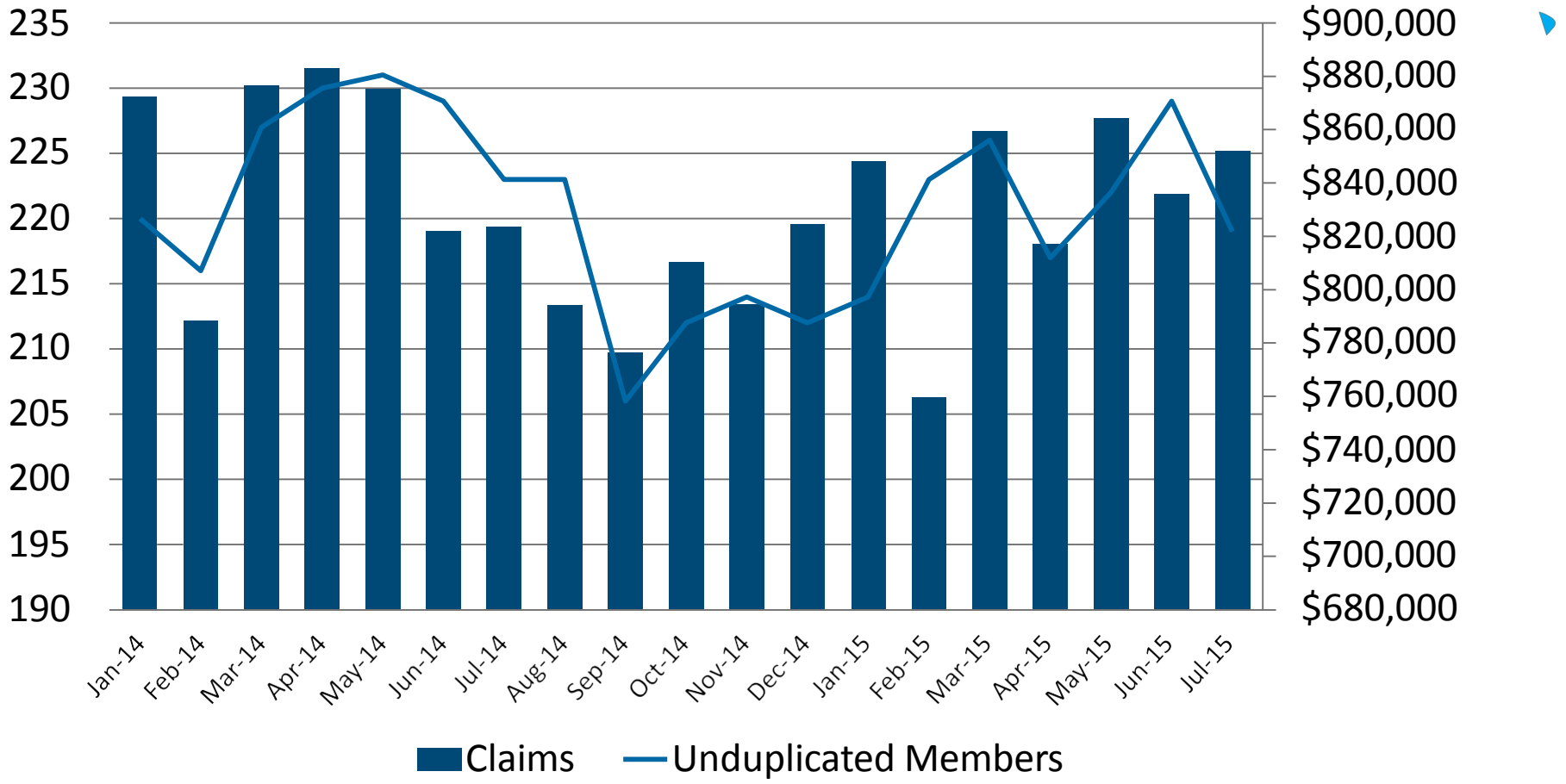
Data Source: Claims based Management report SV601

Residential A: Claims paid by Unduplicated Member



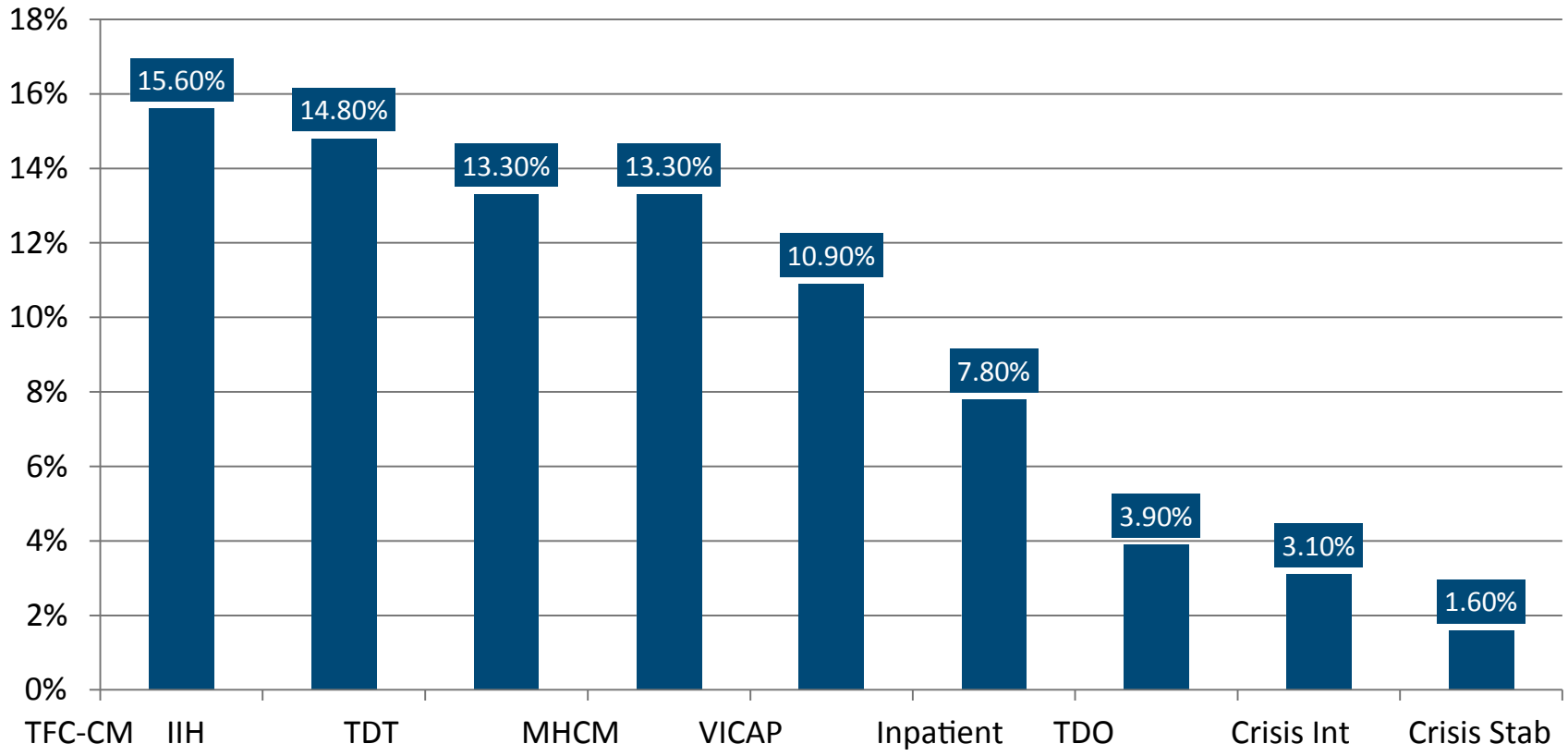
Data Source: Claims-based Management report SV601

Residential B: Claims paid by Unduplicated Member



Data Source: Claims-based Management report SV601

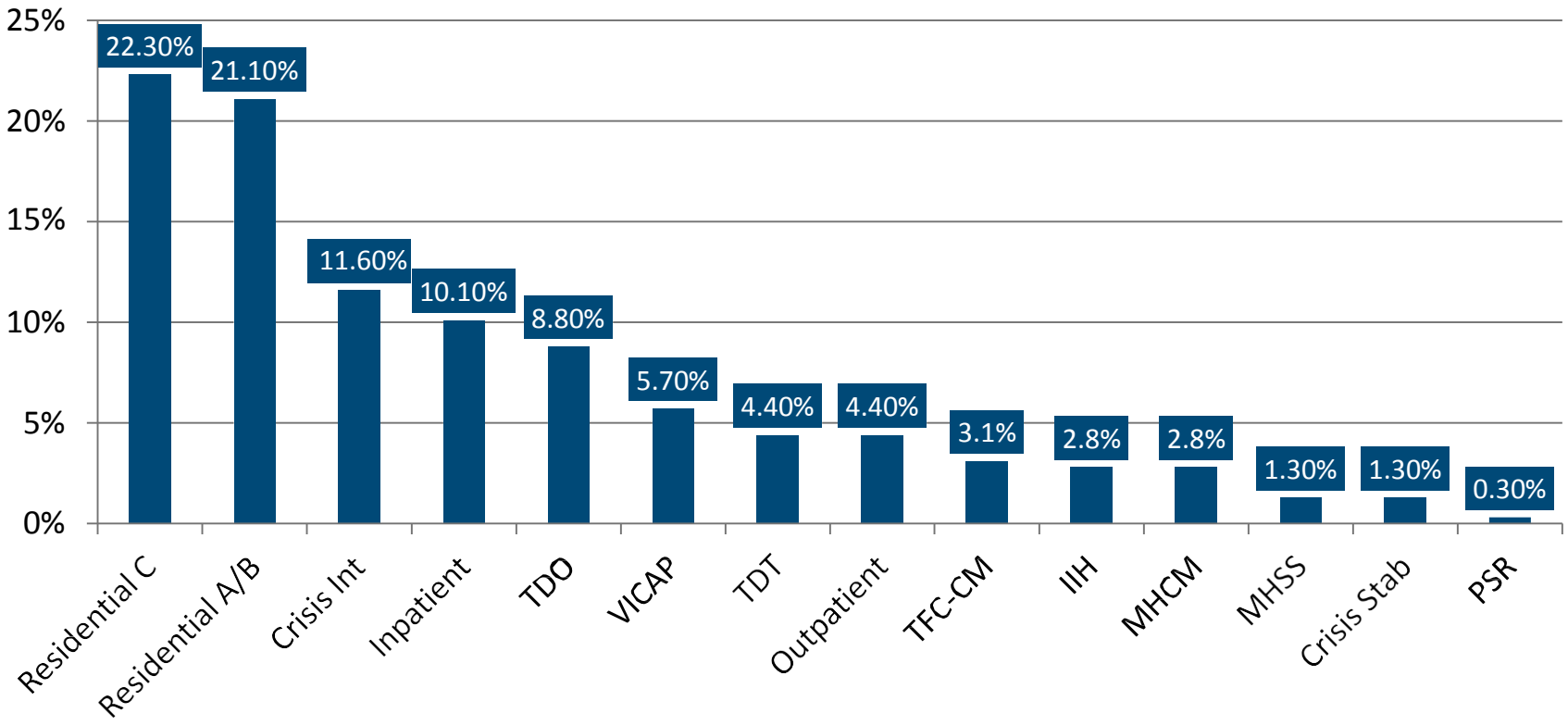
"High Risk" Group: Authorizations prior to Residential Authorization



- *"High Risk" group was defined as having spent greater than 450 days in Residential services or having 4 or more initial authorizations for Residential services.*
- *28.3% of high risk members had no authorizations prior to the Residential authorization, but had authorization(s) following Residential discharge.*
- *6.2% of high risk members had no authorizations prior to the Residential authorization or following Residential discharge.*

Data Source: Ad hoc Query: Residential authorization IP data run 9/21/15

"High Risk" Group: Authorizations following Residential discharge



Data Source: Ad hoc Query: Residential authorization IP data run 9/21/15

RTC Project Update

DMAS Authority

DMAS has budget authority to make changes to residential treatment services.

Budget item 301.PP states:

- "The Department of Medical Assistance Services shall make programmatic changes in the provision of Residential Treatment Facility (Level C) and Levels A and B residential services (group homes) for children with serious emotional disturbances in order ensure appropriate utilization and cost efficiency. The department shall consider all available options including, but not limited to, prior authorization, utilization review and provider qualifications. The department shall have authority to promulgate regulations to implement these changes within 280 days or less from the enactment date of this act."

RTC Project Overview

- Goal:

  Promulgate Emergency Regulations that govern the Level A, B and C Residential Treatment Services and address the individualized service needs of the EPSDT program

RTC Project Overview

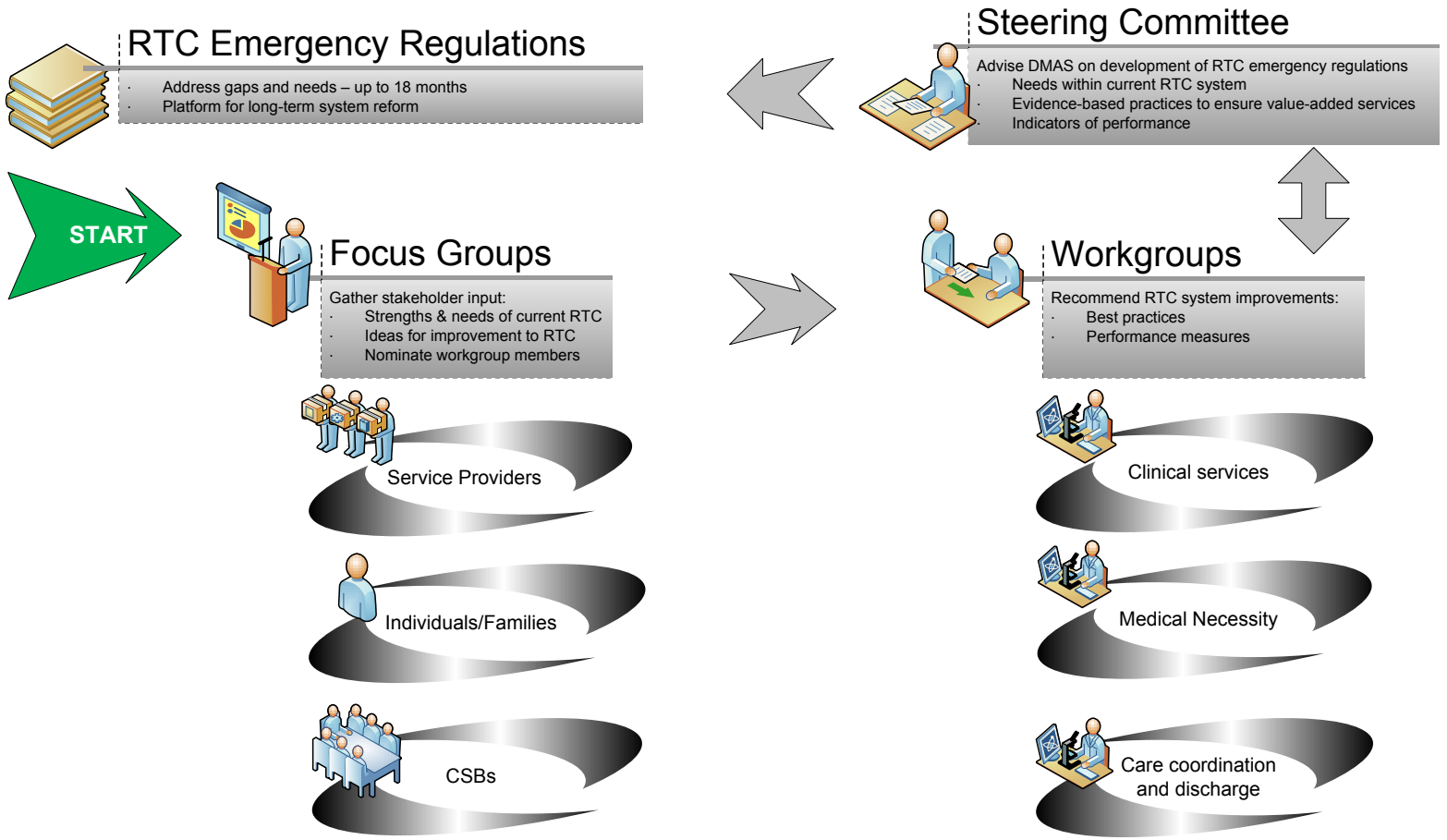
- Mission:

  Transition three of our most complex programs into models with evidence based treatment approaches, standardized medical necessity criteria, and rigorous program requirements.

RTC Project Overview

- The objectives of the program changes will be:
  - To achieve a more efficient service model that yields better outcomes to the individual served using shorter duration and high intensity services.
  - To embed care coordination that ensures effective programming and a successful return to the community and home settings.

PROJECT PLAN



FOCUS GROUPS

Session summaries available:

- Level A
- Level B
- Level C
- Children and Family Services Committee, VACSB
- Parents

FOCUS GROUPS

Common themes:

- "System" varies widely across the state.
- Effective care coordination is essential but currently lacking, i.e., providers, parents, local agencies/CSA, community-based providers.
- Care must be outcomes driven and decisions based on measurable evidence.
- Overly prescriptive program requirements hinder individualized and effective care.

STATUS: Medical Necessity Criteria

- VA ceases use of InterQual 12/1/2015
- Magellan's national medical necessity criteria will be implemented
  - Level C – essentially final; refinements continue while regulations are implemented
  - Level A/B – refinements continue.
  - EPSDT – draft criteria delivered to workgroup members for comment 11/11/2015

NEXT STEPS: MNC

- Workgroup will review draft EPSDT MNC.
- EPSDT Group Home MNC needs to be developed or decide to use the RTC model
- Additional stakeholder input will be sought on Level A/B, "Therapeutic Group Home" MNC.
- Magellan's 12/1 MNC will serve the program until the implementation of the Emergency Regulations and the new rules.
- Next Magellan Training: 11/20/2015

MNC Changes pending

- New Magellan criteria requires psychiatric evaluation prior to admission
- DMAS is consulting with the Managed Care Plans to develop methods that will be used to ensure immediate access to this service.
- Most cases are covered by an MCO upon admission, their networks are able to handle this demand.

STATUS: PROGRAM REQUIREMENTS

- Workgroup has reviewed current requirements. Recommendation highlights:
  - Reduce prescriptive requirements; examine implementation of individualized service plan; allow justified deviations.
  - Require evidence-based/informed, trauma-informed practices.
  - Align DMAS, DBHDS, DHP requirements.
  - Recognize non-therapy parent activities as "parent involvement," e.g., psychoeducation.
  - Require evidence of discharge planning beginning at admission.
  - Consider daily v. weekly requirements (utilization review).

NEXT STEPS: PROGRAM REQUIREMENTS

- Workgroup to review EPSDT program requirements once developed and shared.
- Review and provide comments to proposed requirements
- DMAS is evaluating comments currently

STATUS: CARE COORD/DISCHARGE

- Recommendations of Care Coordination Workgroup are reflected in program requirements documents, and include:
  - Establish provider as responsible for care coordination and discharge planning, in collaboration with treatment team.
  - Establish specific activities to facilitate discharge: identify and link to community-based services/providers prior to d/c.
  - Require BHSA review of discharge plan.

ISSUES IDENTIFIED

1. Level A care
   - Issue: Treatment services appear to require a DBHDS license.
   - Level A and Level B use the same medical necessity criteria, the individual must require treatment to be authorized for services
2. Independent certification teams
   - Issue: Inconsistent practices, limits to member choice, may not meet CMS standards in all cases
   - Status: DMAS continuing research

ISSUES IDENTIFIED

Care Coordination

- Ongoing assessment is needed to evaluate progress
- Providers and local systems do not have a standard way of assessing treatment needs
- Discharge planning is impacted by local provider engagement and provider knowledge of service availability in each locality
- Admission and discharge practices are inconsistent. Information is not standardized from treatment providers prior to admission

Next Steps

- DMAS is drafting regulatory language to use in the Emergency Regulations
- The regulatory text will be reviewed by workgroup members soon.
- DMAS is considering approaches that will ensure consistent care coordination approaches
- DMAS is evaluating the Certificate of Need Process

Next Steps

- DMAS plans to meet with workgroups via conference call to review proposed solutions to the Certificate of Need and Care Coordination processes
- Options are still being considered

Thank You

Brian Campbell
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Division of Integrated Care and Behavioral Services
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COMMONWEALTH OF VIRGINIA

Commission on Youth

The Use of Federal, State, and Local Funds for Private Educational Placements of Students with Disabilities Year 2

Virginia Coalition of Private Provider Associations

November 12, 2015

Leah Mills

Virginia Commission on Youth

Background

- The Commission on Youth is a standing legislative commission of the Virginia General Assembly.
- It was established in statute, §30-174 and §30-175, by the 1989 General Assembly.
- It provides a legislative forum in which complex issues related to Virginia youth and their families can be explored and resolved.

Virginia Commission on Youth

Role

- Virginia Code §30-174 states that the Commission shall "study and provide recommendations addressing the needs of and services to the Commonwealth's youth and families."
- The Commission's primary areas of concern are:
  - Child Welfare
  - Education
  - Child Health
  - Child Mental Health
  - Juvenile Justice
- The Commission conducts its studies through research and data analysis, generally with guidance from Advisory Groups providing subject expertise.

Virginia Commission on Youth

Membership

The Commission is composed of six delegates, three senators and three citizens appointed by the Governor.

Delegate Christopher K. Peace, Chair
Delegate Richard L. Anderson
Delegate Mamye E. BaCote
Delegate Richard P. Bell
Delegate Peter F. Farrell
Delegate Mark Keam

Senator Barbara A. Favola, Vice-Chair
Senator Dave W. Marsden
Senator Stephen H. Martin
Deirdre Goldsmith
Frank Royal, M.D.
Charles Slemp, III, Esq.

Virginia Commission on Youth

2014 Studies and Initiatives

- Early Childhood Education – Workgroup on Quality
- Use of Restraint and Seclusion in Schools
- Court-Appointed Attorneys in Child Welfare Cases
- Unlawful Adoption of a Child
- Three Branch Institute on Child Social and Emotional Well-Being (Year Two)
- Collection of Evidence-based Practices for Children and Adolescents with Mental Health Treatment Needs (Biennial Update)
- The Use of Federal, State, and Local Funds for the Private Educational Placements of Students with Disabilities (Year One)

Virginia Commission on Youth

2015 Studies and Initiatives

- Evidence-based Practices for Children and Adolescents with Mental Health Treatment Needs (Biennial Update)
- Temporary Placements of Children
- Implementation of School Divisions' Concussion Policies
- The Use of Federal, State, and Local Funds for the Private Educational Placements of Students with Disabilities (Year Two)

Virginia Commission on Youth

The Use of Federal, State, and Local Funds for Private Educational Placements of Students with Disabilities Year 2

Study Mandate

- HJR 196 (Adams) directs the Commission on Youth (COY) to:
  - examine the use of Comprehensive Services Act for At-Risk Youth and Families* (CSA) and Medicaid funds for private day and private residential special education placements;
  - gather local and statewide data when youth are placed in these placements;
  - determine the feasibility and cost-effectiveness of more integrated alternatives to provide special education services to students including students with intellectual and developmental disabilities currently in segregated settings; and
  - consider any other matters appropriate to meet the objectives of this study.
- COY is to complete its meetings by 11/30/14 the first year and by 11/30/15 the second year and report recommendations prior to the 2016 General Assembly Session.

*The 2015 General Assembly enacted legislation (SB 850, Favola) to change the name of the Comprehensive Services Act for At-Risk Youth and Families to the Children's Services Act (CSA) to better reflect the goals of CSA.

Study Activities – Year 1 & 2

- Conduct literature reviews on other states' initiatives/ policies
- Review federal statues and regulations
- Review Virginia laws and regulations
- Review CSA Policies
- Collect data to review the use of special education placements
- Met with state and local officials, as well as key stakeholders
- Site visits
- Convene Advisory Group
  - June 15 Meeting
  - September 8 Meeting

Background

- Special education, pursuant to the IDEA is specially designed instruction provided at no cost to the parents in order to meet the unique needs of a child with a disability.
- IDEA guarantees a free appropriate public education (FAPE) to all eligible children with disabilities including:
  - identification and referral,
  - evaluation,
  - determination of eligibility,
  - development of an individualized education program (IEP),
  - determination of services, and
  - reevaluation.

Background

- Child with a disability – a child's educational performance must be adversely affected due to the disability.
  - Intellectual Disability
  - Hearing impairment
  - Speech or language impairment
  - Visual impairment
  - Emotional disability
  - Orthopedic impairment
  - Autism
  - Traumatic brain injury
  - Other health impairment
  - Specific learning disability
  - Deaf-blindness
  - Multiple disabilities
  - Developmental Delay

Sources: Center for Parent Information and Resources. (2012); Virginia Department of Education. (September 16, 2014). *Fundamentals of Special Education*. Presentation to the Virginia Commission on Youth.

Background

- IDEA requires that students with disabilities be provided special education services in the least restrictive environment (LRE).
- To ensure that all students are educated in the least restrictive environment that is most appropriate for their individual needs, IDEA requires that school divisions have a continuum of alternative placement options.
- Removal from the regular education environment may occur only if the nature and severity of the disability is such that education in regular classes cannot be achieved satisfactorily using supplemental aids and services.
- Placements to educational settings outside the regular classroom are made by the IEP team, with parental involvement, once it has been determined that the student's unique educational needs require another environment.

Background

Continuum of Options

- Regular class – 80% or more
- Regular class – greater than 40% and less than 80%
- Regular class less than 40%
- Public Separate School
- Private Day School
- Public Residential School
- Private Residential School
- Hospital
- Correctional Facility
- Home-based

Source: Virginia Department of Education. (June 15, 2015). *Special Education in Virginia*. Presentation to the Virginia Commission on Youth Advisory Committee on the Use of Federal, State, and Local Funds for Private Educational Placements of Students with Disabilities.

Background

Private Day and Residential Programs

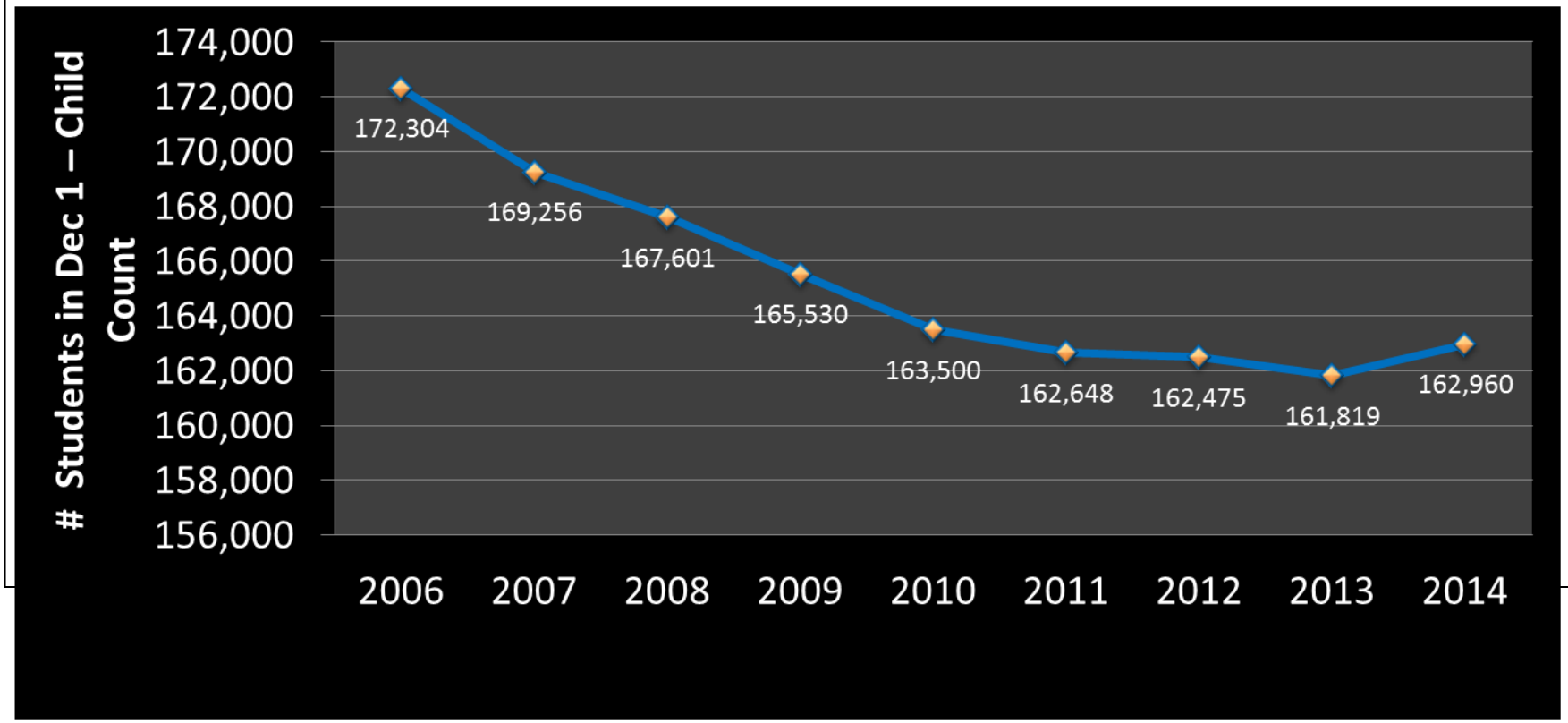
- For students with significant disabilities, a private day or residential program may be considered the least restrictive environment.
- This decision is based on the child's IEP and reviewed annually.
- The Virginia Department of Education (VDOE) is responsible for licensing:
  - residential schools for children with disabilities in the Commonwealth, as specified by § 22.1-319 through § 22.1-335 of the *Code of Virginia;* and
  - private education programs for the children with disabilities, as specified by § 22.1-218 of the *Code of Virginia.*

Special Education in Virginia

1.273 million students in Virginia

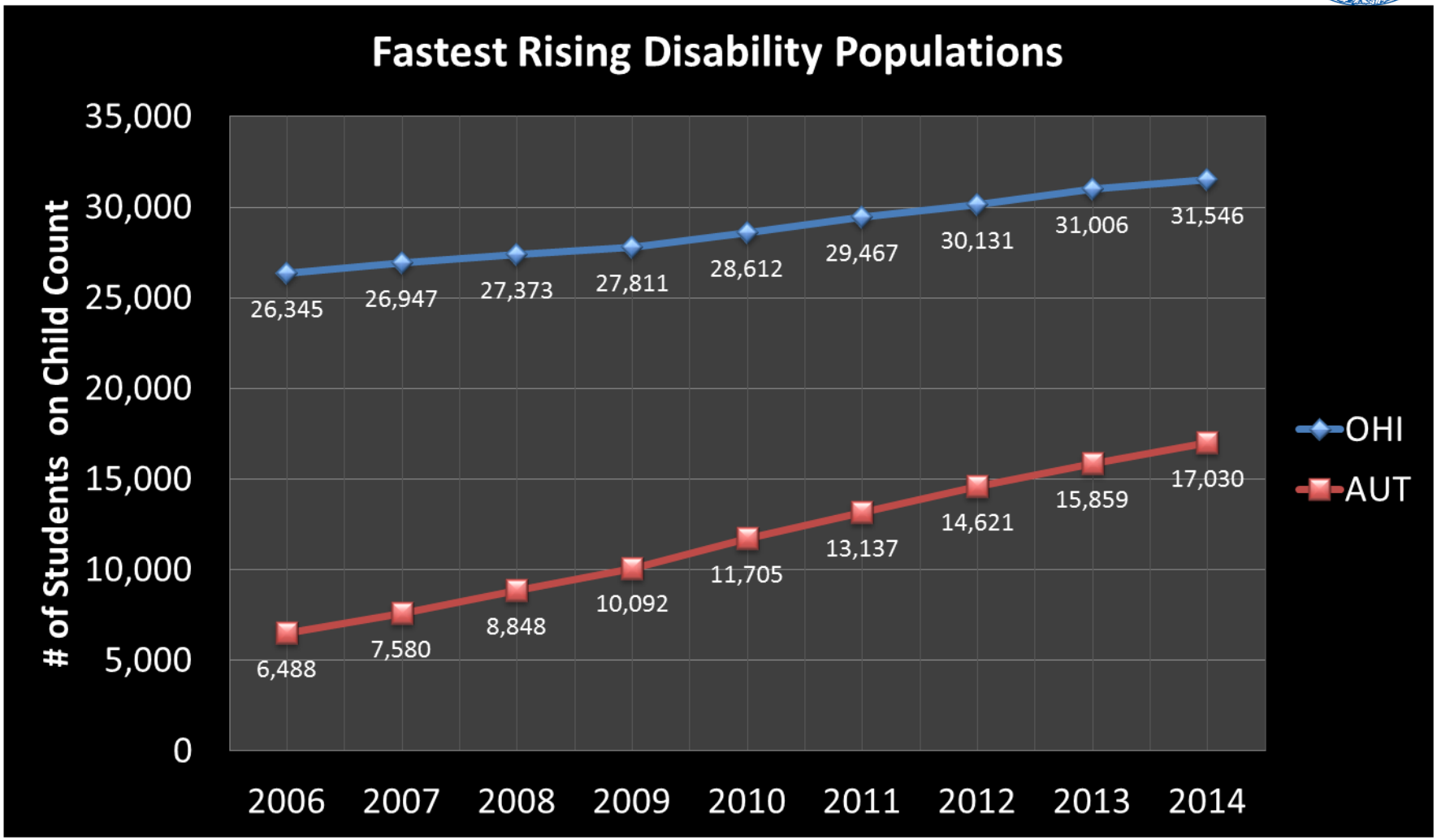
162,960 students with disabilities (SWD)

- Represents 12.3% of the overall school population
- Many SWD categories decreasing



Source: Virginia Department of Education. (June 15, 2015). *Special Education in Virginia*. Presentation to the Virginia Commission on Youth Advisory Committee on the Use of Federal, State, and Local Funds for Private Educational Placements of Students with Disabilities.

Special Education in Virginia



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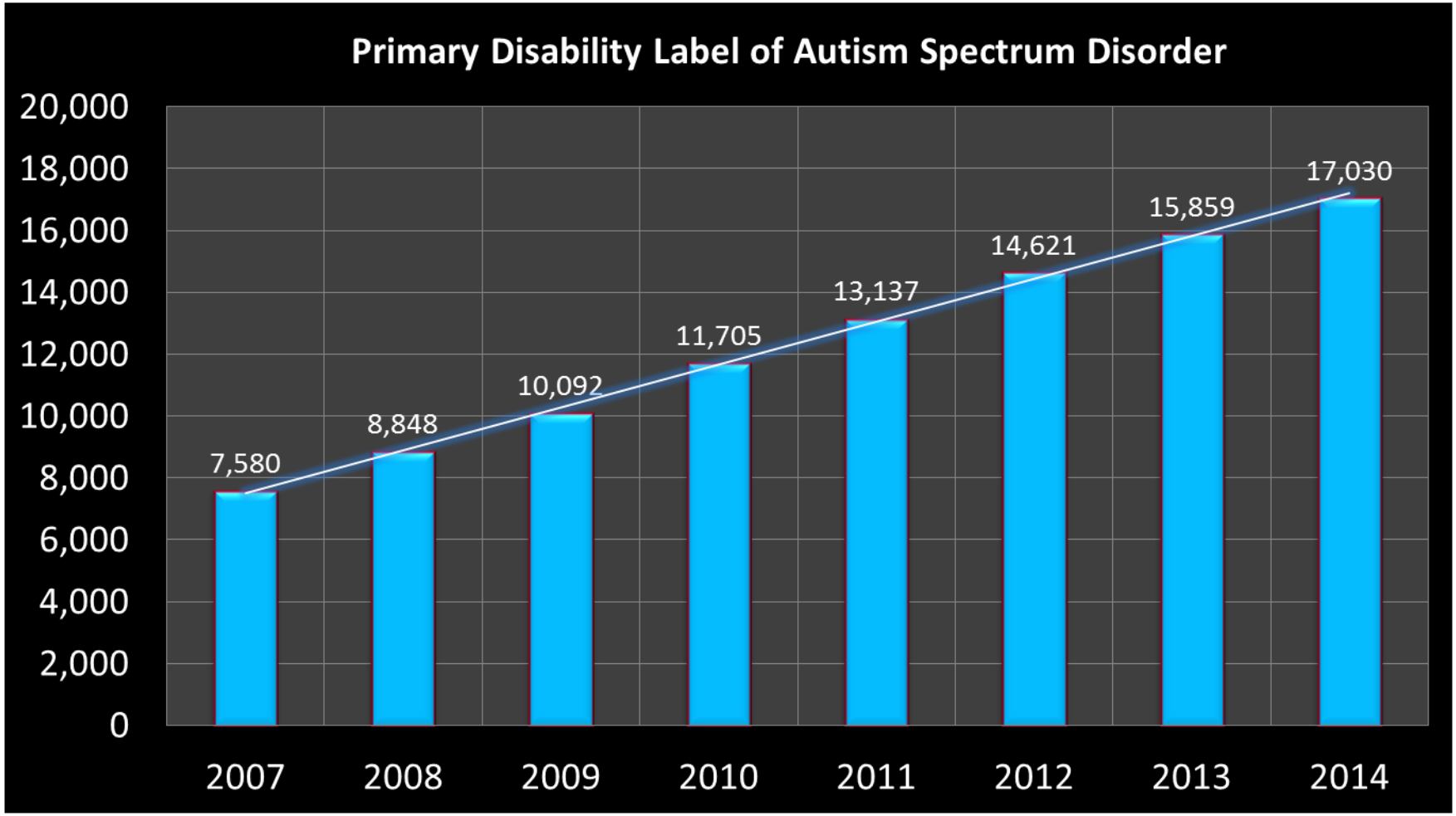
Special Education in Virginia



Source: Virginia Department of Education. (June 15, 2015). *Special Education in Virginia*. Presentation to the Virginia Commission on Youth Advisory Committee on the Use of Federal, State, and Local Funds for Private Educational Placements of Students with Disabilities.

Special Education in Virginia

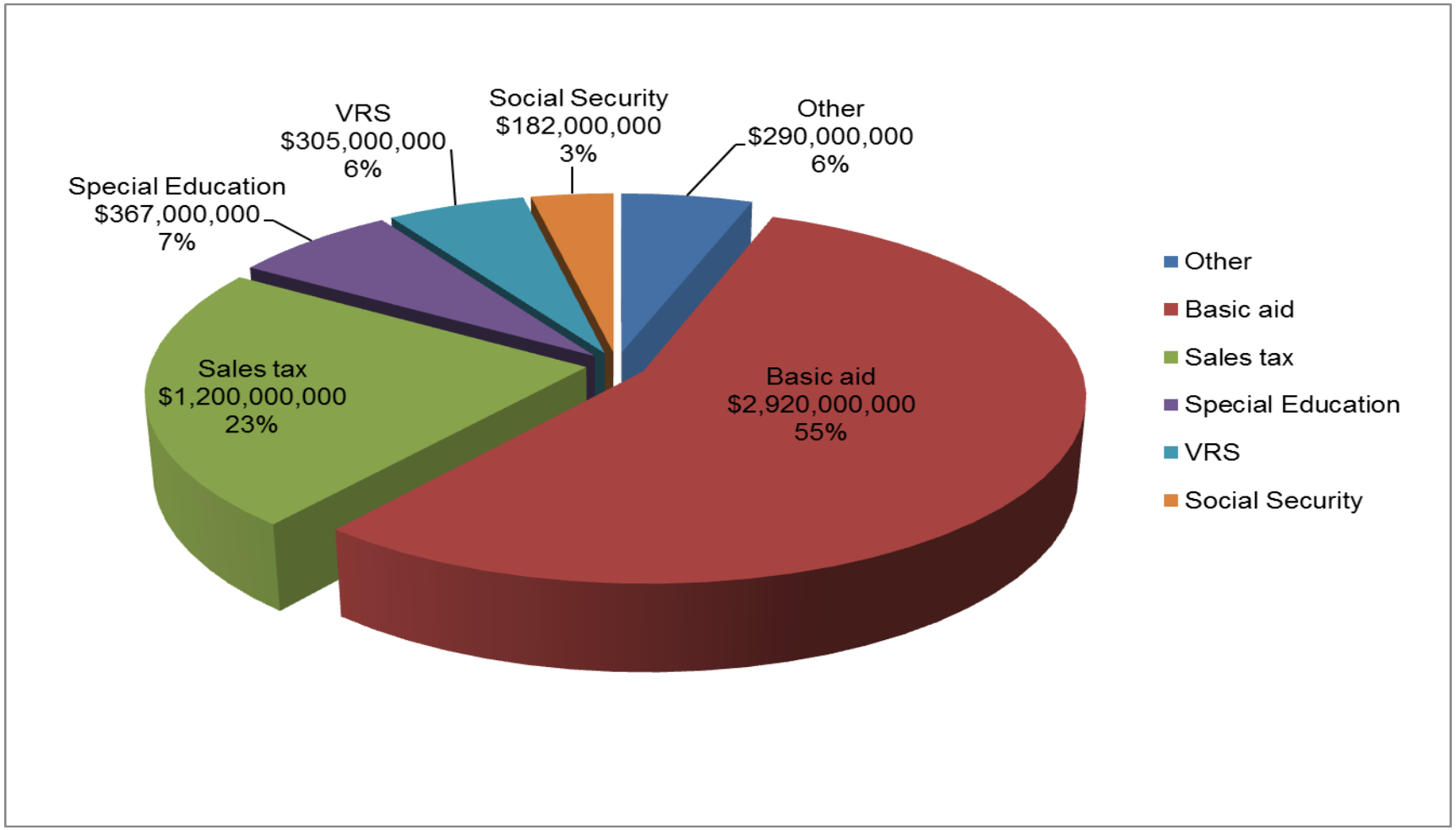
Funding

- State general funds support special education services in public school settings.
- For each child counted in the school division's average daily membership (ADM), an amount is paid to the school division for this purpose. This per-child amount is referred to as the special education add-on.
- The state's share of this cost is determined according to the locality's composite index of local ability to pay.

FY	Total	Total Child Count Minus Regional Tuition Students	Avg. Per Pupil Cost
FY 2013	$2,092,221,649	158,262	$ 13,219
FY 2014	$2,128,858,916	157,723	$ 13,497

Special Education in Virginia

Payments by VDOE to School Divisions FY 2014



Source: Joint Legislative Audit Review Commission. (2014). State Spending on the K-12 Standards of Quality: FY 2014.

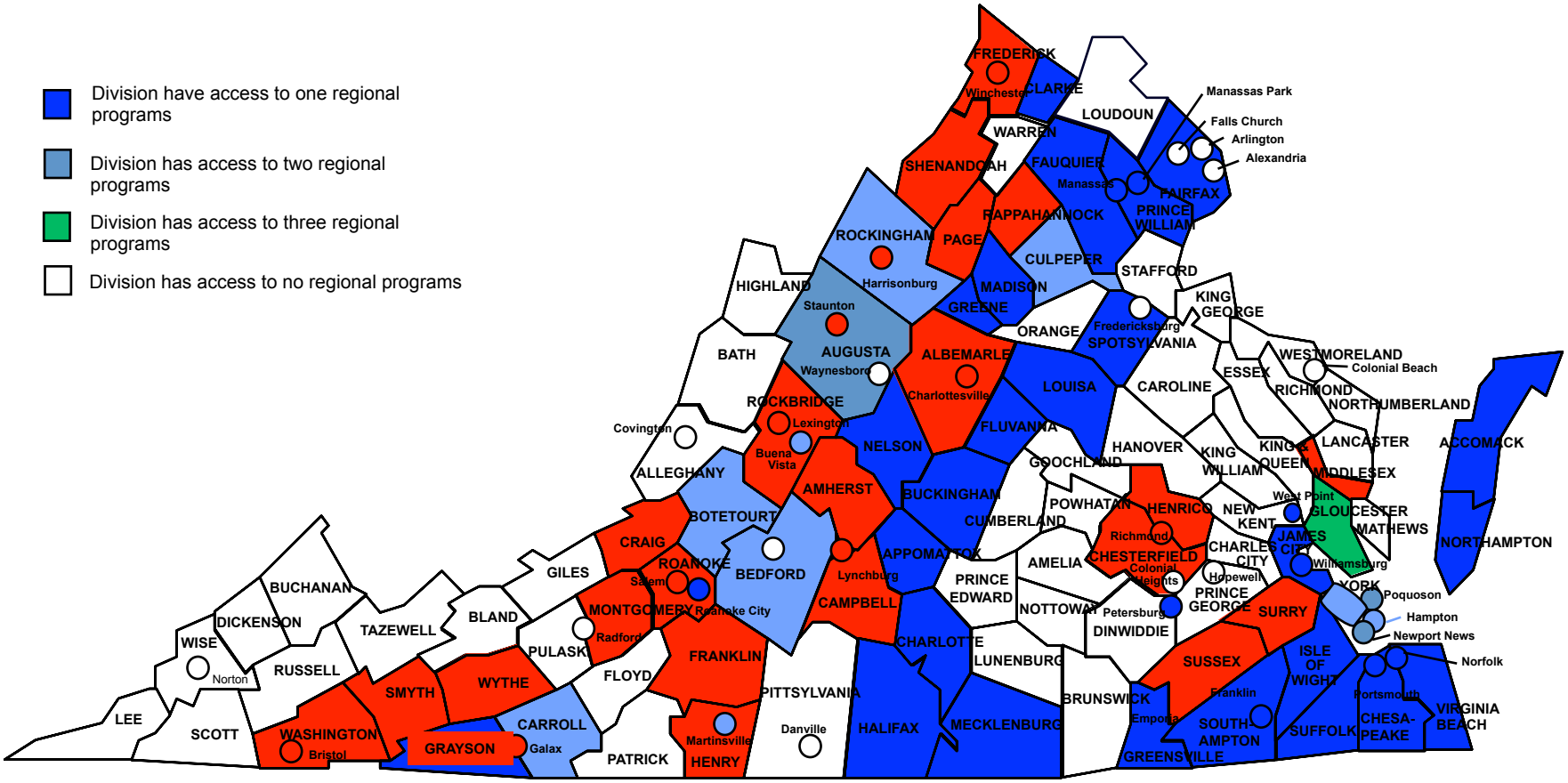
Special Education in Virginia

Funding – Regional Tuition Reimbursement

- Regional special education programs created in the 1970's
- Original purpose was to create regional classrooms for low-incidence disabilities where there were not enough children in one division to justify the cost of a teacher
- There are 11 approved regional tuition reimbursement programs.
- State regional tuition funds are available to school divisions who claim regional tuition reimbursement for students served in regional special education programs (a local match is required).
  - Emotional Disabilities (ED), Deaf-Blindness (DB), Autism (AUT), Traumatic Brain Injury (TBI) - Only
- Regional programs are not considered out-of-school placements, as regional programs are public schools.

Total FY 14	State Share FY 14	Local Share FY 14	Children Served	Avg. Pupil Cost
$129,893,418	$75,711,068	$54,182,350	4,464	$29,097

School Divisions' Access
Virginia's Regional Special Education Programs



Source: Virginia Commission on Youth Graphic.

Special Education in Virginia

Funding – Children Services Act (CSA) for Private Day/ Residential Placements

- CSA funds are used to fund private day school and residential placements for the purposes of special education.
  - If placement in a private day or residential program is necessary to provide special education and related services to a child with a disability, the program, including nonmedical care and room and board, shall be at no cost to the parents of the child. (34 CFR §300.104)
  - Local school divisions shall be responsible for payment of transportation expenses associated with implementing the child's IEP.

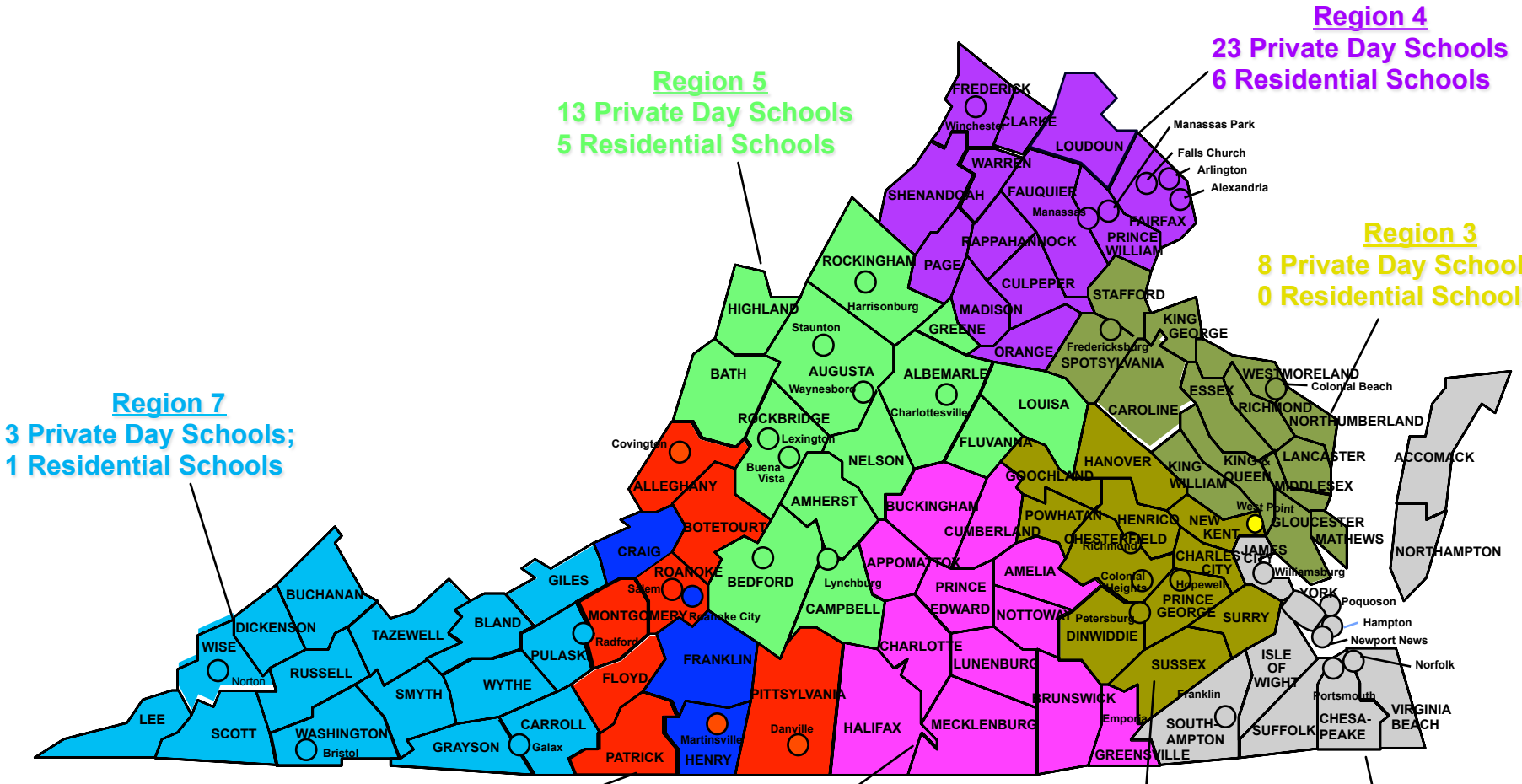
Special Education in Virginia

Funding – Children Services Act (CSA) for Private Day/Residential Placements

- CSA policies and procedures may not interfere/impede the delivery of services in accordance with IDEA.
- Local policies/procedures vary.
- Community Policy and Management Teams (CPMTs) cannot deny funding of a private day or residential placement included in a student's IEP.

Source: Virginia Department of Education. (2011). CSA and Special Education Frequently Asked Questions.

VDOE Licensed Private Day Schools by Region



Source: Virginia Department of Education Licensed Private Schools for Students with Disabilities 2014-2015.

Special Education in Virginia

Funding – CSA Wrap-Around Funds

- CSA wrap-around funds for services for students with disabilities
- Funds community services to prevent a more restrictive placement
- Fall outside the area of responsibility of the schools
- Recommended by the Family Assessment and Planning Team (FAPT)
- $2.2 million is earmarked for services.
  - Funding is allocated based on formula to requesting localities.
  - Localities are required to appropriate a local match.
  - While these funds are considered mandated, localities do not have to utilize these funds and many chose not to do so.

Special Education in Virginia

Funding – Medicaid

- Medicaid funds may be used to pay for health-related services provided under IDEA for students with an IEP.
- Virginia school divisions enroll directly with the Department of Medical Assistance Services (DMAS) for the reimbursement of select health services for children with Medicaid or FAMIS coverage.
- DMAS-covered services for children in special education are provided by the school division according to the child's IEP.
- School divisions use local and state funds to draw down the federal Medicaid share.

Special Education in Virginia

Schools divisions' requirements for Medicaid reimbursement

- Services must be specified in the child's IEP
- Current license on file with VDOE for each service practitioner
- Signed provider agreement with DMAS
- Parent/guardian consent is required for schools to bill DMAS for any health-related services.
- Providers must comply with appropriate service provider qualifications.

Special Education in Virginia

Medicaid-covered services

- Physical therapy
- Occupational therapy
- Speech-language therapy
- Audiology
- Psychiatric, psychology, and mental health evaluations
- Nursing services
- Personal care
- Medical evaluations
- Specialized transportation

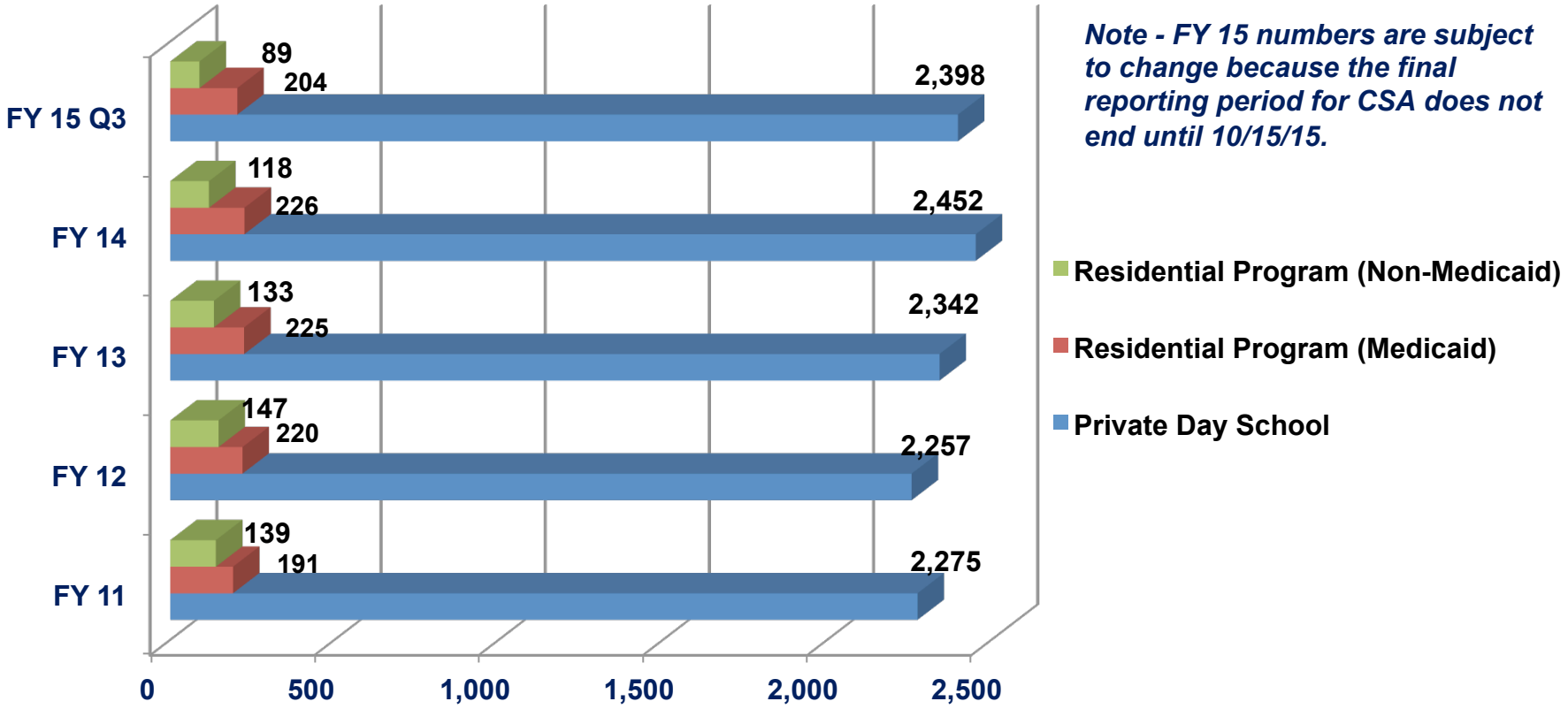
Special Education in Virginia

Medicaid Claims

- Medical and transportation claims are submitted and paid throughout the year.
- Claims must also be cost settled annually.
- The federal share is distributed 95% / 5% between school divisions and DMAS.
- School divisions are eligible for quarterly reimbursement for administrative activities to support the Medicaid program.
  - Examples of these activities include Medicaid outreach, facilitating applications for Medicaid programs, and translation related to Medicaid services.
  - The federal share is distributed 50% / 50% between school divisions and DMAS.
- DMAS reimbursed approximately $24 million for the special education services and approximately $3.9 million for administrative claims for FY 2015.

Special Education Services Under CSA

Number of Youth Served by Placement Type – Special Education Services by Fiscal Year

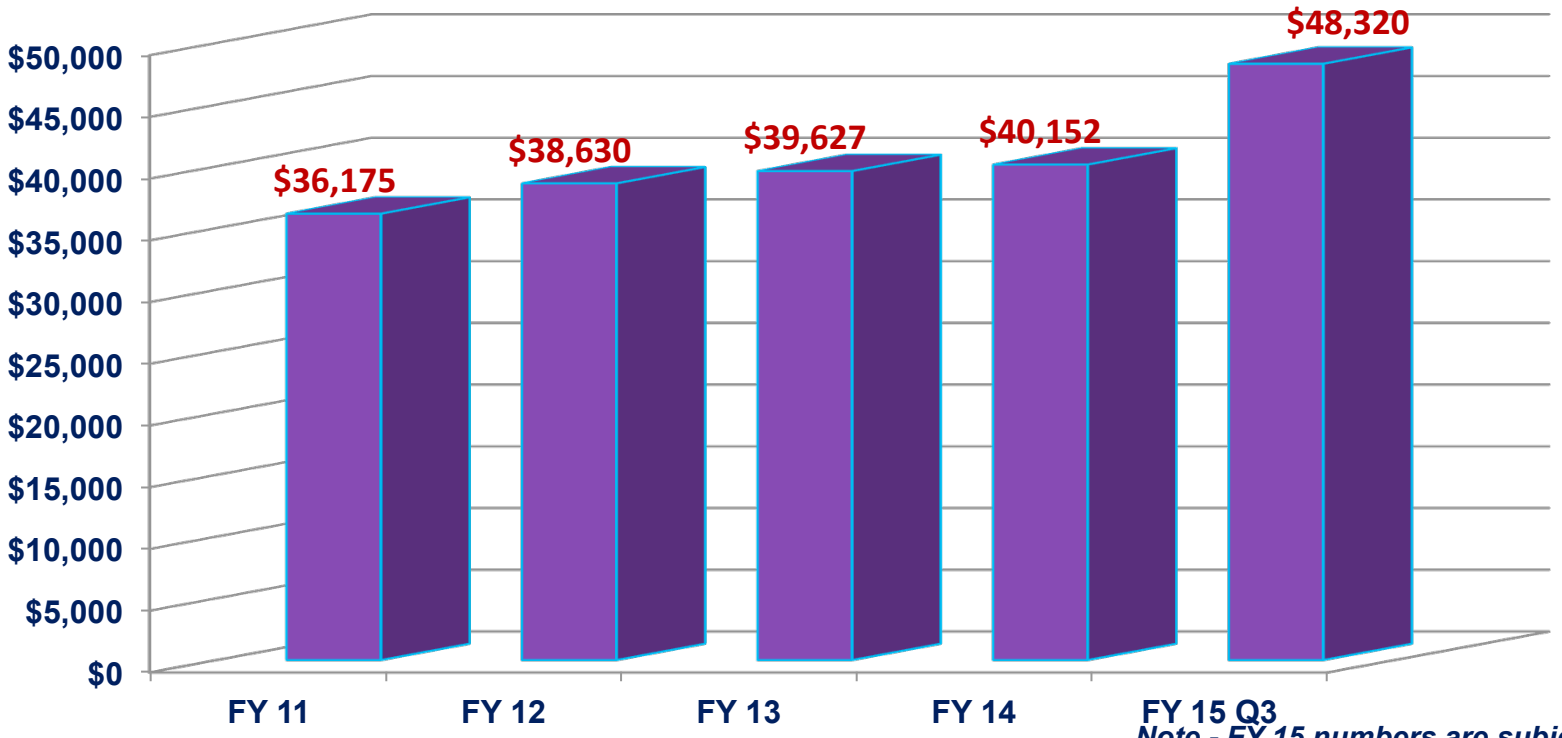


Note - FY 15 numbers are subject to change because the final reporting period for CSA does not end until 10/15/15.

Source: Office of Comprehensive Services. (2014). Special Education Services under the CSA, Annual Report to the General Assembly. CSA Dataset for Q3 FY 15 (reporting period does not end until 10/15/15).

Special Education Services Under CSA

Annual Average Expenditure Per Child – Special Education Services By Fiscal Year (all service types)



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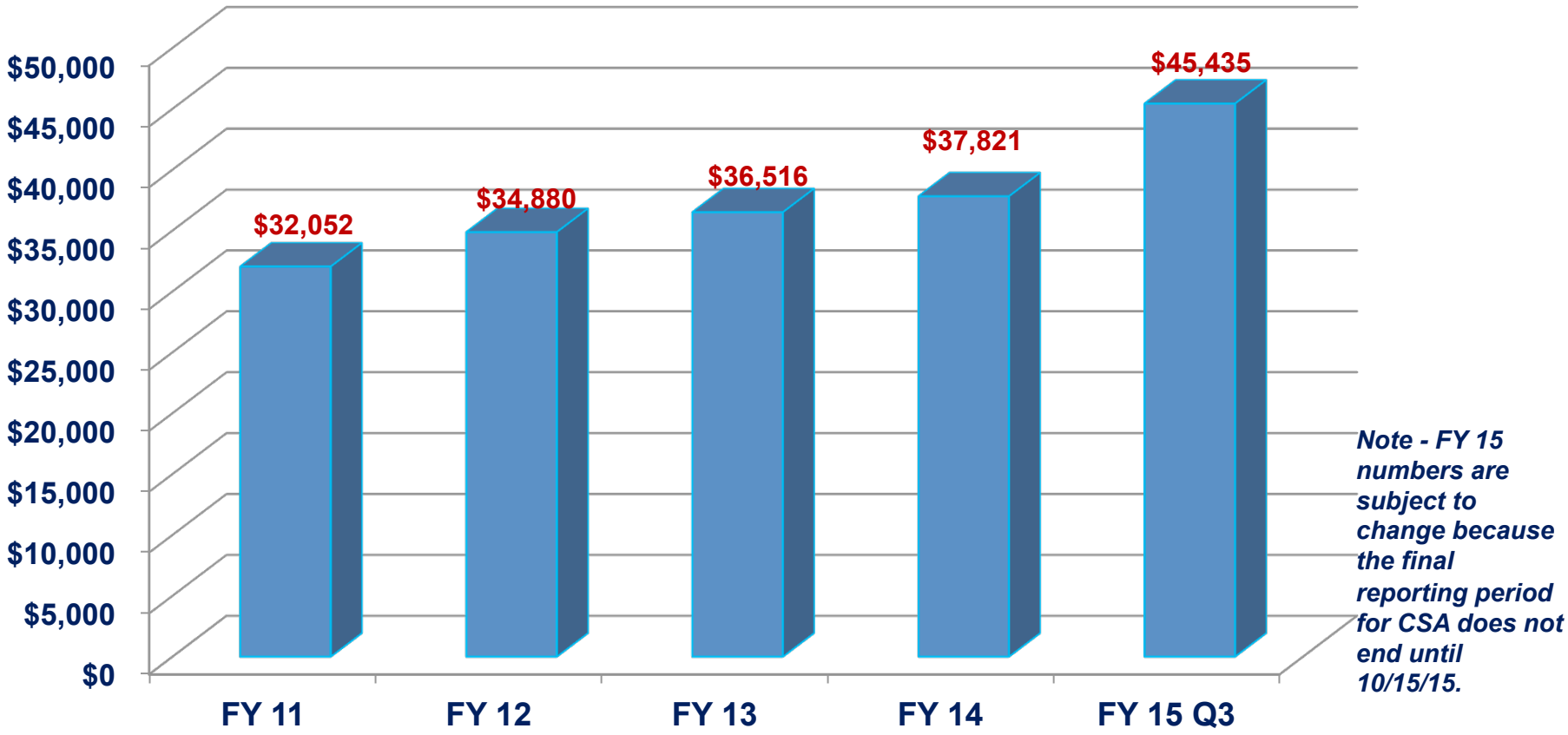
Source: Office of Comprehensive Services. (2014). Special Education Services under the CSA, Annual Report to the General Assembly. CSA Dataset for Q3 for FY 15 (reporting period does not end until 10/15/15).

Special Education Services Under CSA

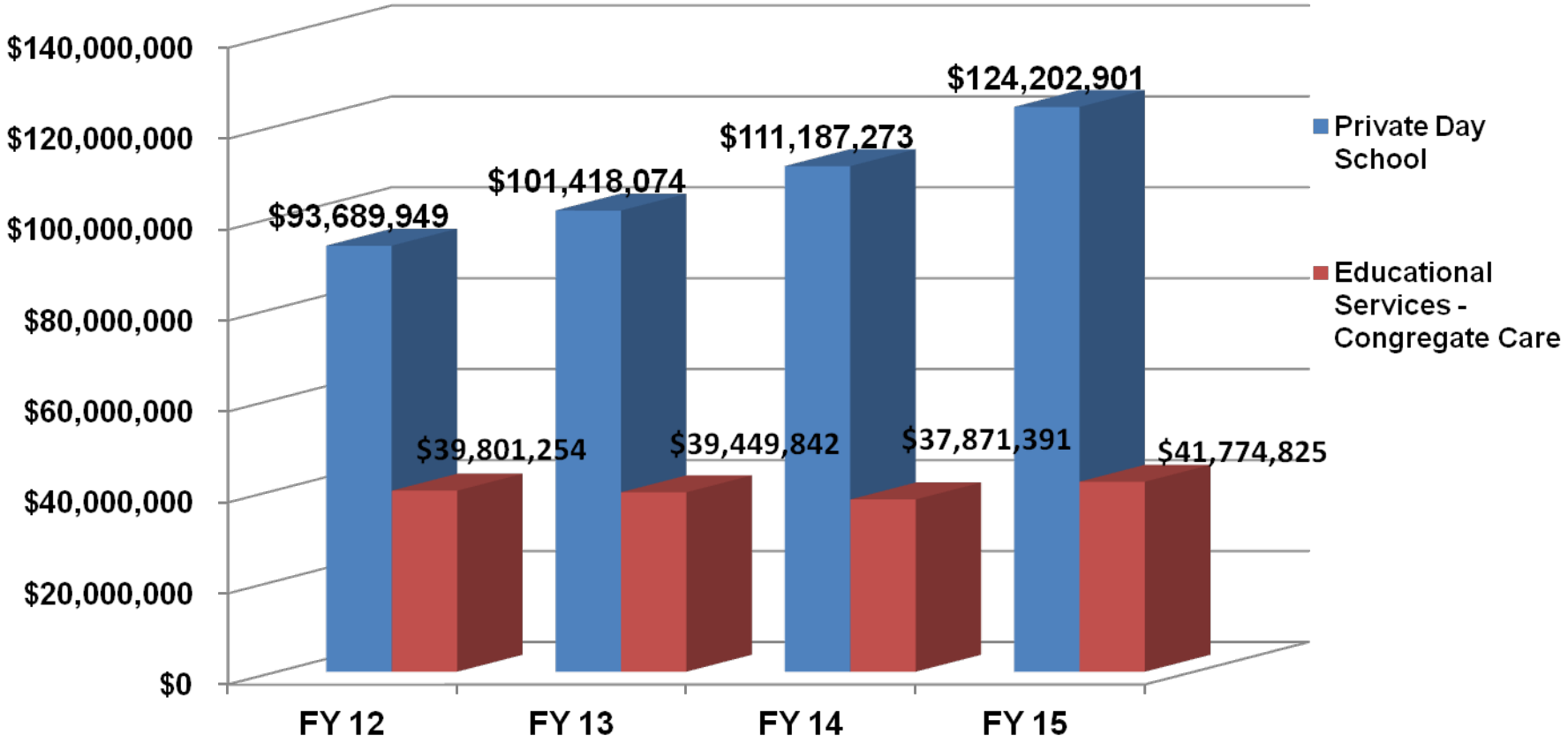
Annual Average Expenditure Per Child – Private Day Placement By Fiscal Year



Source: Office of Comprehensive Services. (2014). Special Education Services under the CSA, Annual Report to the General Assembly. CSA Dataset for Q3 for FY 15 (reporting period does not end until 10/15/15).

Special Education Services Under CSA
(cont.)

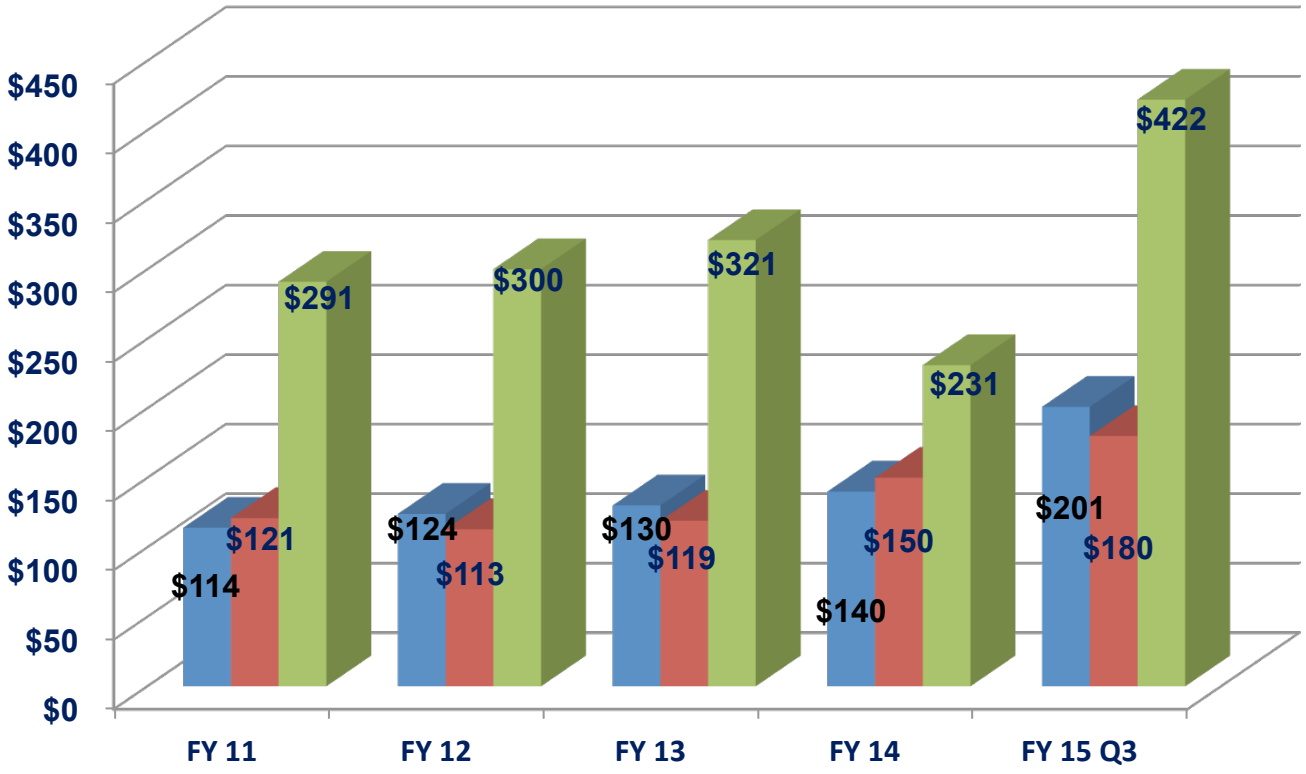
Net Expenditures by Placement Type – Special Education Services by Fiscal Year



Source: Office of Comprehensive Services. (2015). CSA Dataset for FY 15 (reporting period does not end until 10/15/15).

Special Education Services Under CSA

Average Cost Per Child by Placement Type By Fiscal Year

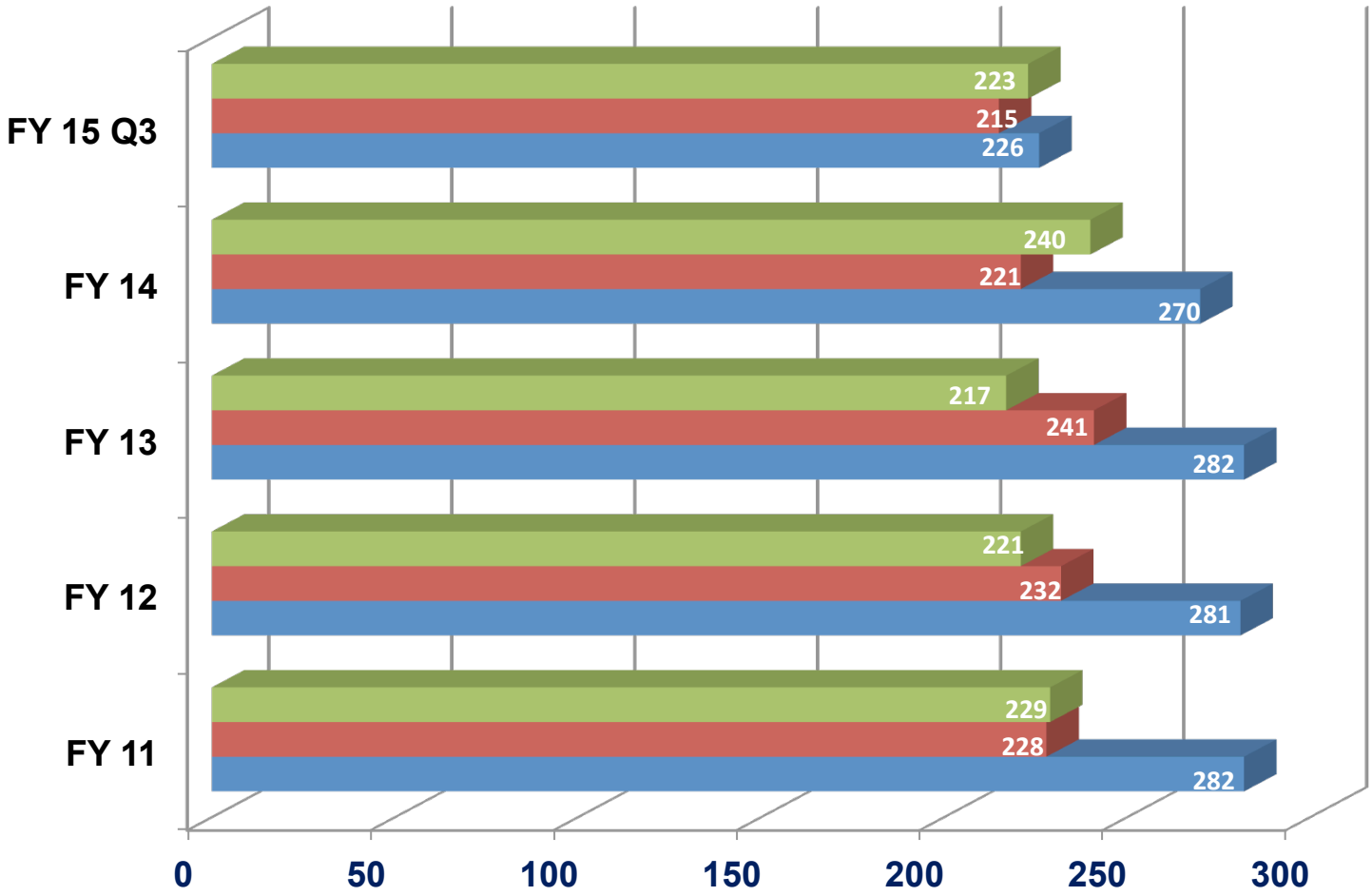


Note - FY 15 numbers are subject to change because the final reporting period for CSA does not end until 10/15/15.

Source: Office of Comprehensive Services. (2014). Special Education Services under the CSA, Annual Report to the General Assembly. CSA Dataset for Q4 FY 15 (reporting period does not end until 10/15/15).

Special Education Services Under CSA

Average Length of Stay (# of Days) by Placement Type by FY



Note - FY 15 numbers are subject to change because the final reporting period for CSA does not end until 10/15/15.

- **Residential Program (Non-Medicaid)**
- **Residential Program (Medicaid)**
- **Private Day School**

Source: Office of Comprehensive Services. (2014). Special Education Services under the CSA, Annual Report to the General Assembly. CSA Dataset for Q3 FY 15 (reporting period does not end until 10/15/15).

Key Findings

Virginia Education Expenditures Average Per Pupil Cost by Placement Setting FY 2014

Placement Setting	Total Child Count	Avg. Per Pupil Cost
Public School	158,262	$13,497
Regional Program	4,464	$29,097
Private Day Placement	2,452*	$37,821**
Residential Non-Medicaid	118*	$33,129
Residential Medicaid	226*	$55,408

Source: Virginia Department of Education. (June 15, 2015). *Special Education in Virginia*. Presentation to the Virginia Commission on Youth Advisory Committee on the Use of Federal, State, and Local Funds for Private Educational Placements of Students with Disabilities; Office of Comprehensive Services. (2014). Special Education Services under the CSA, Annual Report to the General Assembly.
*These numbers are also included in VDOE's Child Count numbers.
**This does not include transportation costs for the child.

Key Findings

Strengths in Virginia

- Private day schools/residential schools are valuable partners in the continuum of alternative placements required by IDEA.
- There are existing programs/funding streams which serve students in the LRE.
  - Regional tuition
  - CSA wrap-around funds
    - 2008 Study - localities that utilize CSA wrap-around services for students with disabilities had decreased the number of youth served in private day and congregate education programs over a 2-year period.
  - Locally created public day schools (i.e., Stafford and Albemarle).
- Virginia is one of 9 states to pass the U.S. Department of Education's "IDEA State Report Card."
- There has been improved awareness/diagnostic strategies which have helped identify children with disabilities.

Key Findings

Challenges

- Many students' primary disabilities are accompanied by secondary challenges; the combination of issues makes it difficult to serve these students.
  - Dangerous or significant behaviors where students are disruptive to themselves, other students, or the general school environment
  - Medically complex children
- Involvement by two different agencies (LEA and CSA)
- Federal requirements (IDEA & the Family Educational Rights and Privacy Act [FERPA])
  - Information sharing
  - Financing requirement (e.g., maintenance of effort & excess cost requirements)
  - Interagency collaboration

Key Findings

Challenges

- The existing special education state funding structure may not adequately meet the needs and increasing numbers of hard-to-serve, special education students.
  - May cost school divisions between 8.8 and 13.6 times more to educate than general education students.
- Children with Autism had increased utilization of special educational services (76% vs 7% in the control group)
- Averaged $14, 061 in higher non-health care costs including $8,610 in higher school costs.
- Challenges with using CSA wrap-around services to maintain LRE – *SEC 2011 Policy Clarification on Use of CSA Funds Under the Special Education Mandate*

Key Findings

Challenges

- Once the child is placed in a private day or residential program, the cost of meeting the needs of the child "shifts" from the LEA to the CSA portion of the locality's budget. The local CSA Office is bound by federal law to abide by provisions and placement determinations set forth in the IEP but has no input in the process.

- Many parents want their children served in private placements and may resist transitioning them back to the public school setting. Parents may also be anxious about moving their child from a private day/residential school back to a public school. While transitioning the child back to the LRE is an expectation pursuant to IDEA, the process can be challenging.

Key Findings

Challenges

- The utilization and costs of private placements for special education students in Virginia has increased significantly.

  - The net total expenditures for private day placements under CSA have increased by $13,015,629 (11.7%) between FY 14 and FY 15. Net expenditures have increased by 32% since 2012.

  - Net total expenditures for residential services for special education have increased 5% since 2012 and 10.3% since 2014.

Key Findings

What We Don't Know

- Additional information is needed on Virginia's Regional Special Education Programs – December 8 COY Meeting
- Incomplete data for CSA private day and residential placements for FY 2015 – December 8 COY meeting
- There is a lack of unified data on needs and outcomes for students placed in private day/residential placements.
  - How are children in CSA-funded private day and residential placements doing?
    - Assessment scores
    - Transitioning to post-secondary education or the workforce

Adopted Recommendations

Finding #1 – There are challenges with using CSA wrap-around services to maintain students in the least restrictive environment (LRE).

1.Request the SEC revisit existing policy restrictions and budgetary constraints with CSA state pool funds for wrap-around services for students with disabilities. This review will include whether the community match rate could be utilized, existing parental co-payment policies for additional services not included in the IEP, and the prohibition on using funds for non-educational services provided by school employees, and make recommendations to improve both utilization and access to these funds to the Commission on Youth by the 2017 General Assembly Session.

Adopted Recommendations

Finding #2 – Virginia's existing special education state funding structure does not adequately meet the needs and increasing numbers of hard-to-serve, special education students.

1. Request VDOE include in its analysis of regional special education programs other states' funding formulas and policies identified during the course of their study that may be employed in the Commonwealth. VDOE shall also determine the efficacy of Virginia's regional special education programs and assess whether provisions are needed to revise these programs and if these programs should be expanded to other regions of the Commonwealth. VDOE shall report findings and recommendations to the Commission on Youth prior to the 2016 General Assembly Session.

Adopted Recommendations

Finding #3 – The utilization and costs of private placements for special education students in Virginia has increased significantly.

1. Introduce a language-only budget amendment stating that localities may require the local share of the Special Education Private Day Placements come from the localities' school boards' budget, rather than the localities' general government budget. **(This Recommendation will be taken up at the Commission's December 8 meeting).**
2. Introduce a budget amendment ~~convening~~ for VDOE to convene an interagency workgroup to assess the barriers to serving students with disabilities in their local public schools. The workgroup shall assess existing policies and funding formulas including school division's program requirements, localities' composite indices, local CSA match rate allocations, local CSA rate setting practices, the impact of caps on support positions, policies for transitioning students back to the public school, and funding for local educational programming based on models which are collaborative and create savings for both local and state government while providing youth an educational option within their communities. Membership shall include a balance of local and state representative, all impacted state agencies, local education agency (LEA) representatives, local CSA representatives, local government officials, local special education administrators, stakeholder organizations, parent representatives, the Arc of Virginia, the Coalition for Students with Disabilities, and members of the Virginia General Assembly. The workgroup shall make recommendations to the Virginia Commission on Youth prior to the 2017 General Assembly Session.

Adopted Recommendations

Finding #3 – The utilization and costs of private placements for special education students in Virginia has increased significantly. (cont.)

3.Request the Office of Children's Services (OCS) collaborate with VDOE and include a track in their annual conference on best practices and effective strategies for serving children with disabilities in the least restrictive environments and increase knowledge and understanding on working with students with disabilities, and their parents, as well as improving coordination between schools and CSA.

4.Request the OCS include in its annual training plan strategies best practices and effective strategies for serving children with disabilities in the least restrictive environment and increase knowledge and understanding on working with students with disabilities, and their parents, as well as improving coordination between schools and CSA.

Adopted Recommendations

Finding #4 – Virginia's Regional Special Education Programs allow select school divisions to serve students in a less restrictive environment but the existing structure needs to be re-evaluated.

Recommendation 1 for Finding 2 was adopted by the Commission which addresses the issues set forth in this Finding.

Adopted Recommendations

Finding #5 – There is no available data about the effectiveness of CSA-funded private day and residential programs.

1.Direct/Request that VDOE work with private providers including the Virginia Association of Independent Specialized Education Facilities, the Virginia Council for Private Education, the Virginia Association of Independent Schools, the Southern Association of Colleges and Schools, the Virginia Coalition of Private Provider Associations, the Virginia Association of Community Services Boards, local school divisions, stakeholder groups, and parent representatives to identify and define outcome measures to assess students' progress such as assessment scores, attendance, graduation rates, transition statistics, and return to the students' home schools.

2.Direct/Request VDOE establish a procedure requiring all assessment scores for private day students tagged as 'Special Situation' be included in the student's "home" school scores.

3.Direct/Request OCS to report annually CANS and CANVaS scores that measure educational outcomes by service placement name and type for all students being served in CSA-funded educational placements.

Adopted Recommendations

Finding #6 – Virginia's parent consent provisions exceed federal regulations and may hinder serving students with disabilities in the least restrictive environment.

1.Request VDOE include in the development of the statewide model IEP, an ongoing planning process which facilitates returning students with disabilities served in private placements to the public school setting. The IEP will establish an ongoing process which should commence when a student with a disability is first placed in a private day or residential school. This process should involve the parents, home school officials, CSA officials, the child's teachers, and other involved stakeholders. VDOE shall also include in its guidance to schools best practices for transitioning students from private residential and private day schools such as employing gradual transition strategies and utilization of available community-based programs. VDOE will investigate the feasibility of incorporating in the statewide model IEP Medicaid billing for services provided to eligible IEP students

Questions/Comments?

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Virginia Economic and Budget Trends What a Difference a Year Makes!

Presentation to

Virginia Coalition of Private Provider Associations

Fiscal Analytics, Ltd.

November 12, 2015

The Good News: Additional 2016-18 Revenues Likely - Even With FY15 Surplus Consumed by Rainy Day Fund

Fiscal Year	Official Growth	Official GF Revenues	Adj. Est. Growth	Adjusted GF Revenues	Difference
2014	-1.6%	$16,411	-1.6%	$16,411	$0
2015	**4.7%**	$17,186	**8.1%***	$17,736*	$550
2016	3.1%	$17,721	3.1%	$18,289	$568
2017	2.1%	$18,092	2.1%	$18,673	$581
2018	3.7%	$18,755	3.7%	$19,364	$609

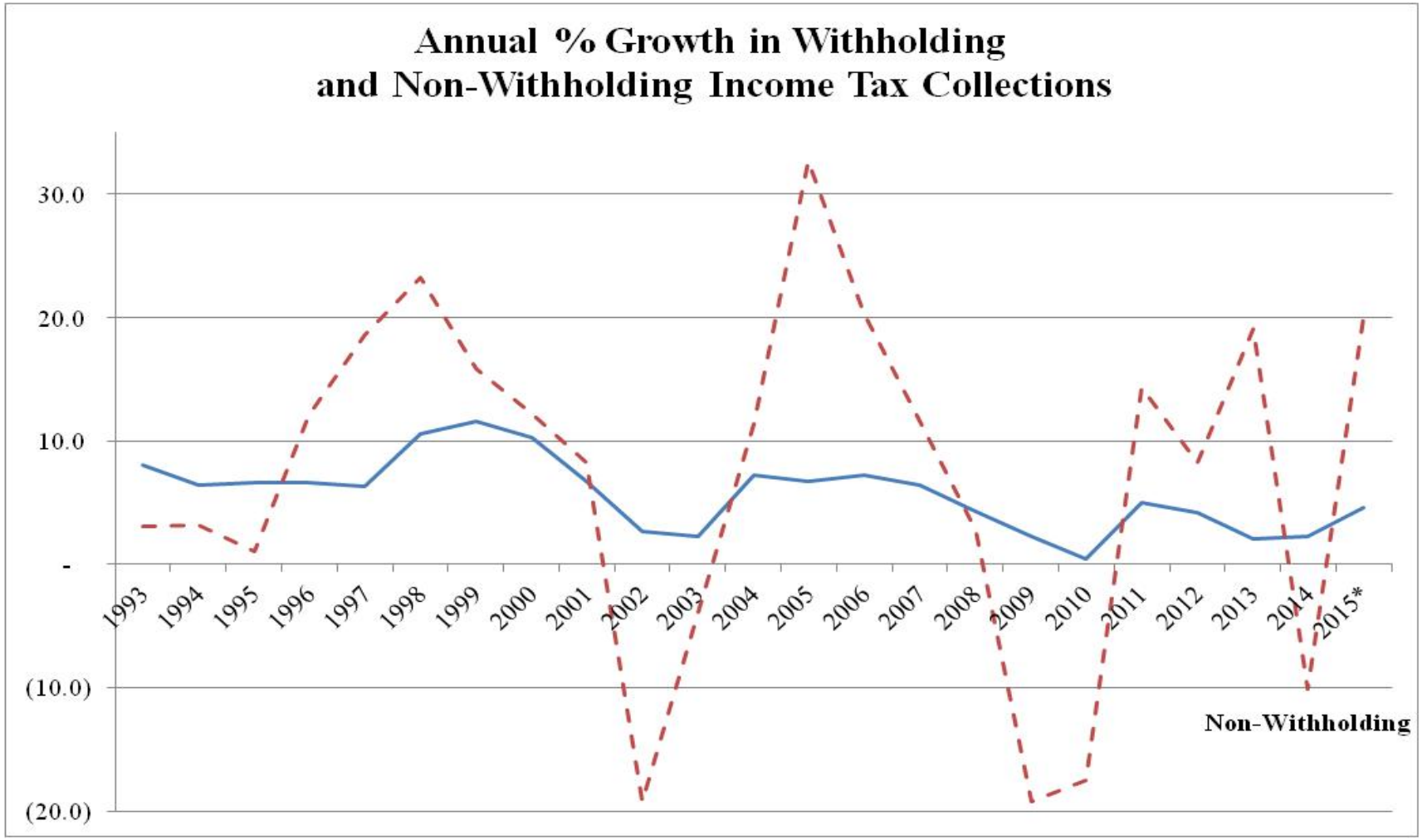
* Preliminary Actual, FY 2015 surplus consumed by Rainy Day Fund constitutional deposit requirements

Will General Fund Growth Rates Perform Better than Expected?

- Revenue forecasting has proven to be especially difficult in recent years.
  - Non-withholding income taxes (16% of GF) hard to forecast. (i.e., higher 2013 federal tax rates amid strong stock market gains).

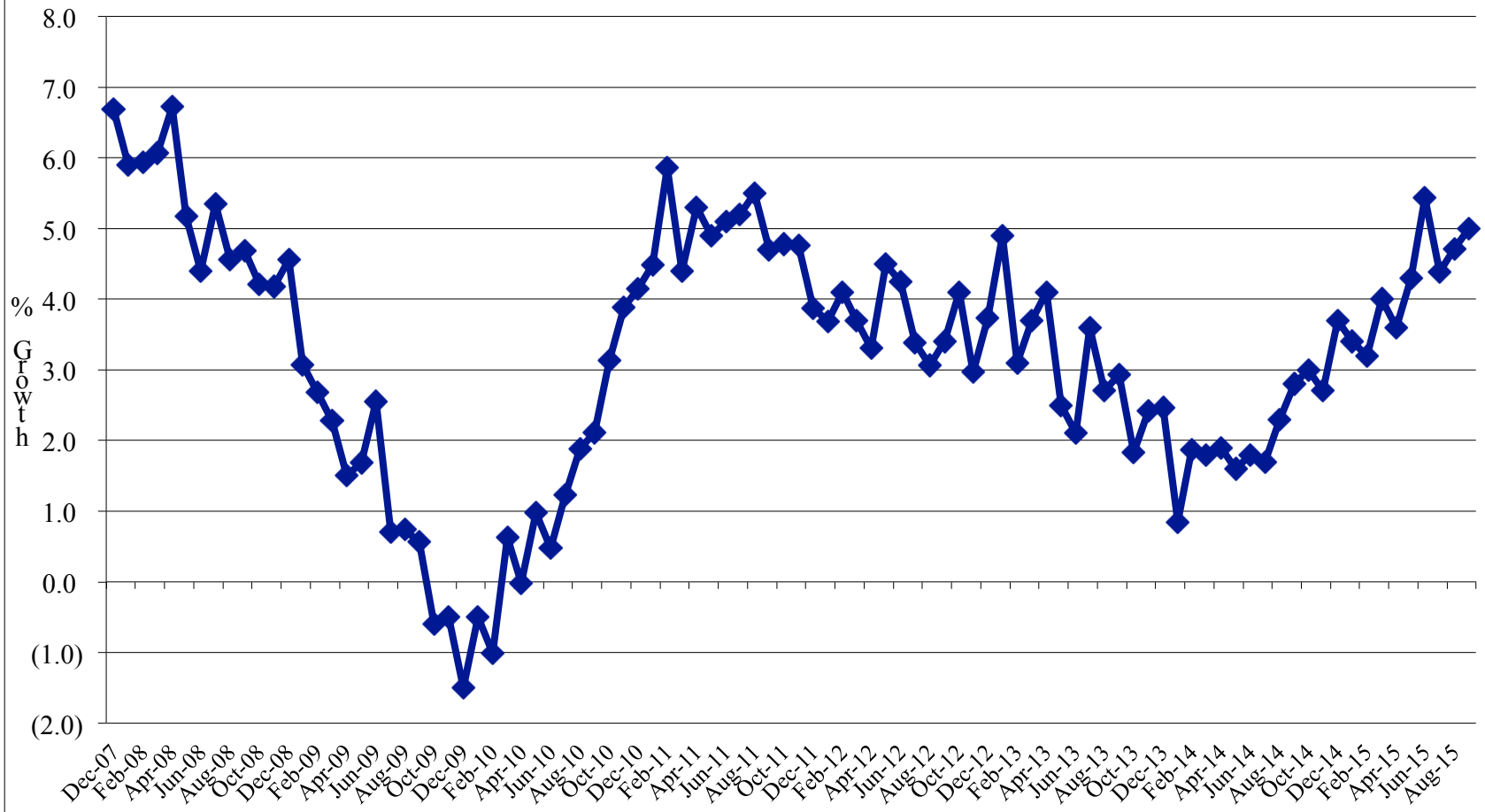
- Virginia economy seems to be improving, even though still under-performing overall U.S. employment and income growth.
  - Income tax withholding (64% of GF) currently growing 4-5%.
  - Recent 2-year federal budget deal with defense spending increases helps Virginia.
  - NoVa employment growth is bouncing back (2.4% yr over yr August growth, stronger professional/business services).

Non-Withholding Income Tax Is a Volatile Revenue Source*

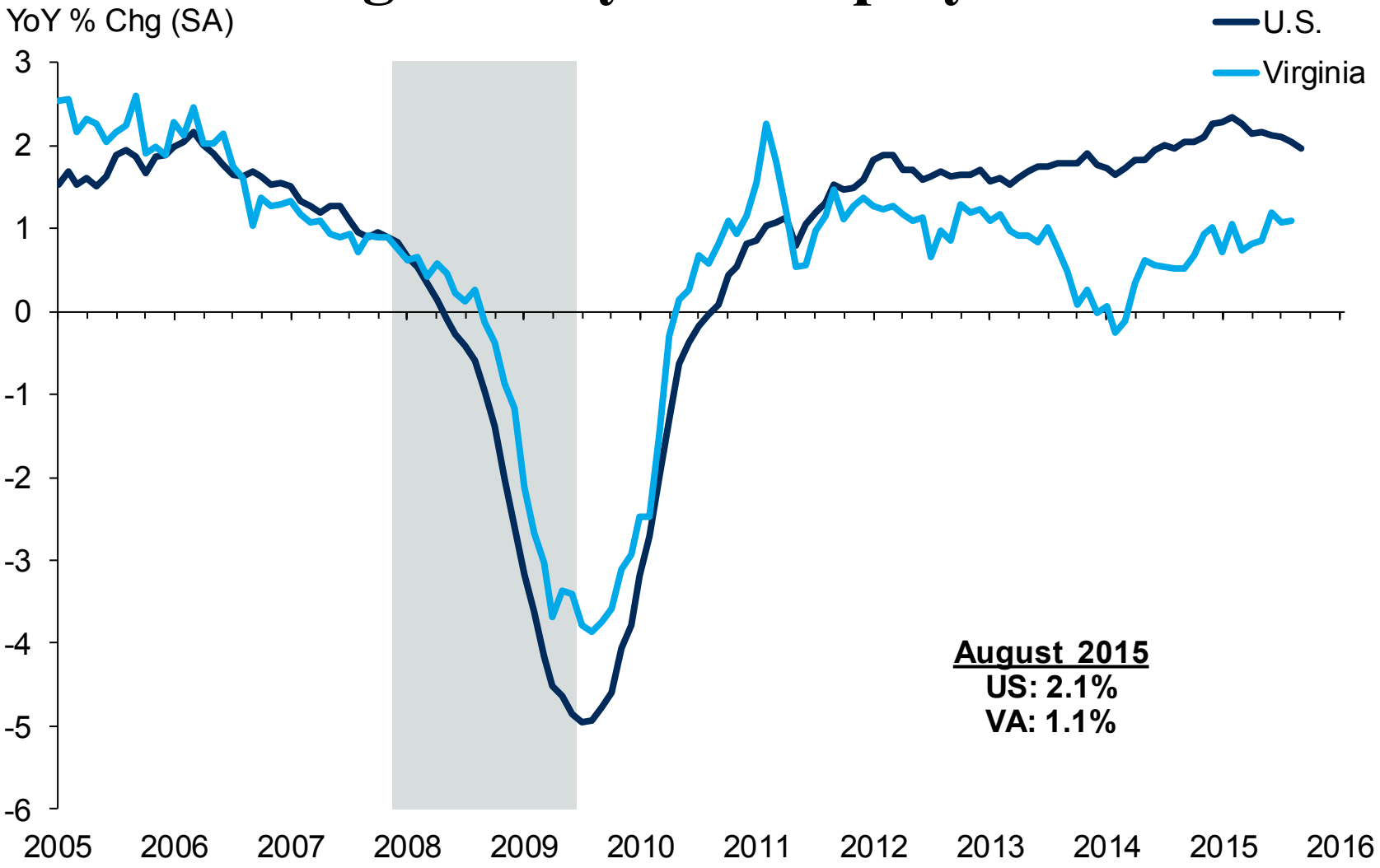


** Note: % of total GF revenues: 15.4% in FY 14; 17.1% in FY 15*

Improving Growth in Individual Income Tax Withholding
(62% of GF; 12 Mo. Moving Avg % Growth Thru Sept.)



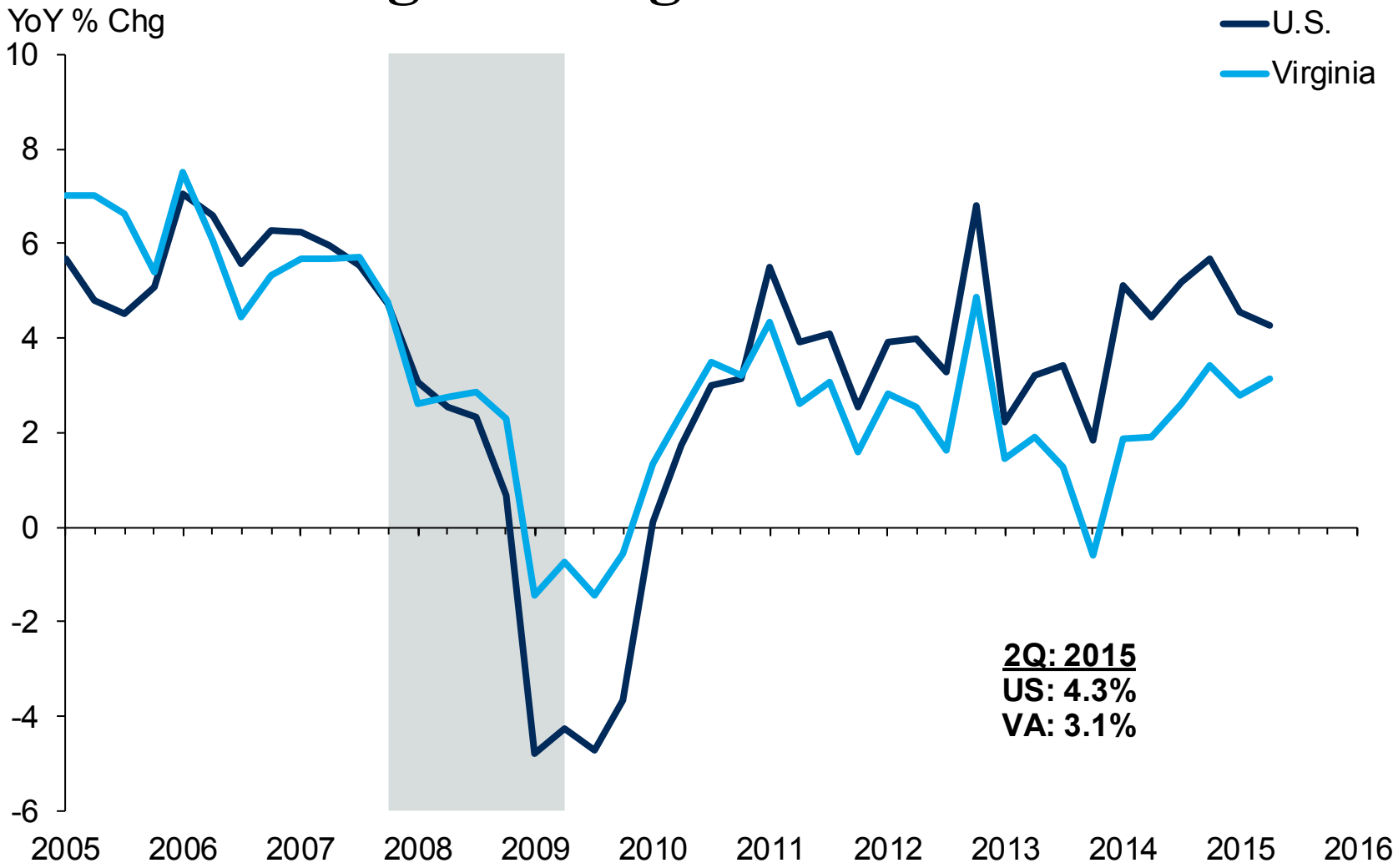
Continued Improvement?
Virginia Payroll Employment



Source: Bureau of Labor Statistics/Haver Analytics

74

Continued Improvement?
Virginia Wages and Salaries



Source: Bureau of Economic Analysis/Haver Analytics

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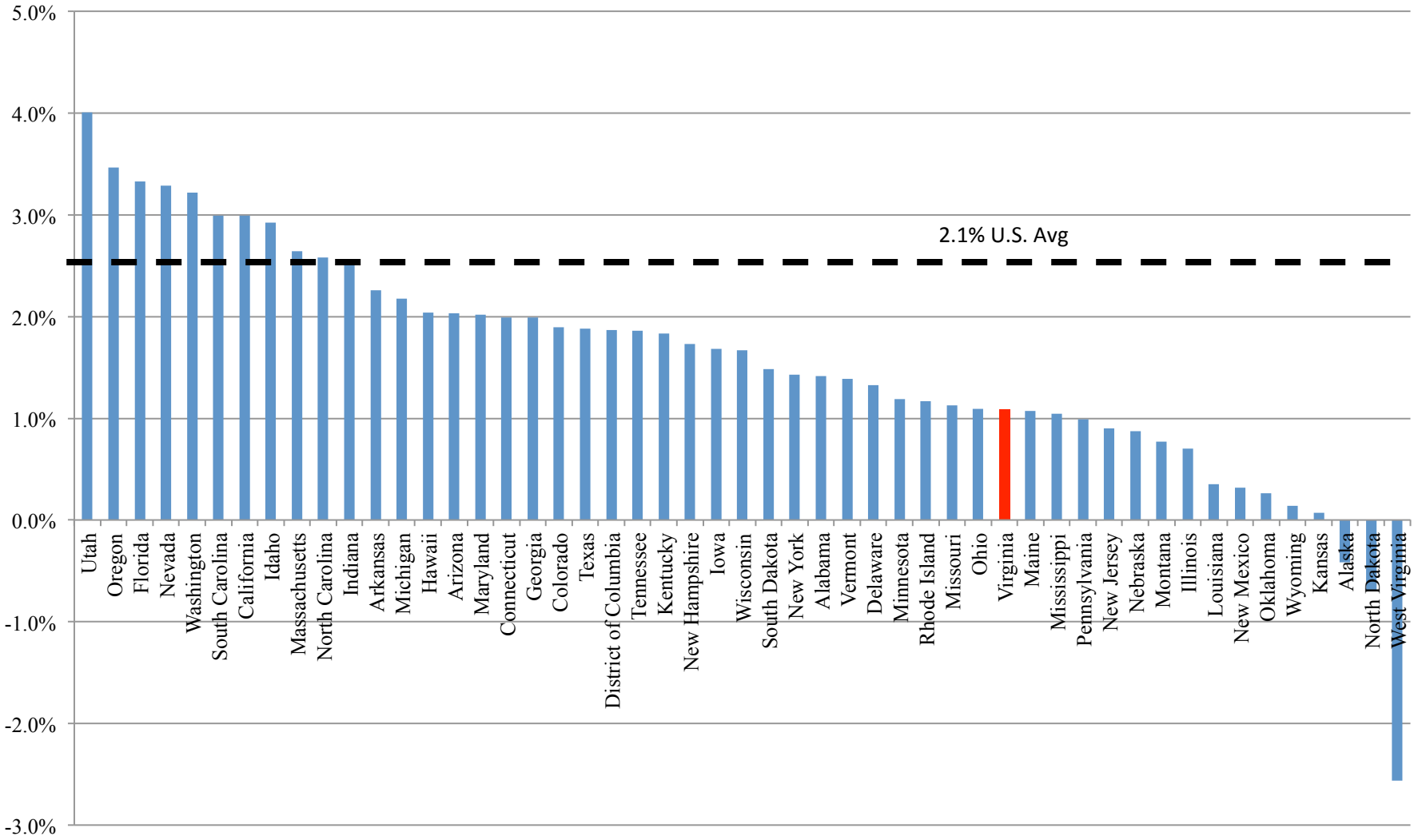
Will VA Return to At-Least National Avg Growth?

August 2015 States' Year-over-Year Employment Growth



Source: U.S. Bureau of Labor Statistics

Current 2014-16 General Fund Appropriations $1.6 Bil. Above its FY 14 Base

		2015 Session Adopted Budget		
	FY 2014 Budget	**FY 2015 Budget**	**FY 2016 Budget**	**FY14-16 over FY14 x 2**
Legislative and Executive Dept's	103.2	109.0	107.7	10.3
Judicial Dept.	425.2	452.6	455.4	57.6
Administration/Comp Board	654.1	689.6	680.5	61.8
Treasury Board GF Debt Service	608.5	672.1	683.7	138.7
Other Finance/Technology	171.8	179.8	181.5	17.5
Rainy Day Fund	339.6	372.7	-	(306.5)
Car Tax Reimbursement	950.0	950.0	950.0	-
Commerce and Trade	183.3	181.9	197.0	12.3
Agriculture / Nat. Resources	144.0	184.3	174.4	70.7
K-12 Education/Central Office	5,292.7	5,456.5	5,615.3	486.5
Higher & Other Education	1,782.1	1,813.6	1,865.5	114.9
DMAS Medicaid	3,519.8	3,694.4	3,987.2	642.0
Other Health & Human Services	1,541.5	1,646.1	1,658.1	221.1
Public Safety & Veterans/HS	1,699.0	1,802.8	1,836.1	240.8
Transportation	42.0	13.2	69.1	(1.7)
Central Appropriations	247.2	20.4	160.2	(313.8)
Independent Agencies/Capital	1.2	1.4	142.6	141.6
Total GF Appropriations	**$ 17,705.2**	**$ 18,240.2**	**$ 18,764.2**	**1,593.9**
GF Resources	**$ 17,304.1**	**$ 18,301.0**	**$ 18,767.3**	
Balances		**$ 186.4**	**$ 1.9**	
Unspent Balance		**$ 247.2**	**$ 5.1**	

Improving Revenues Will Provide Budget Flexibility in the 2016-18 Biennium

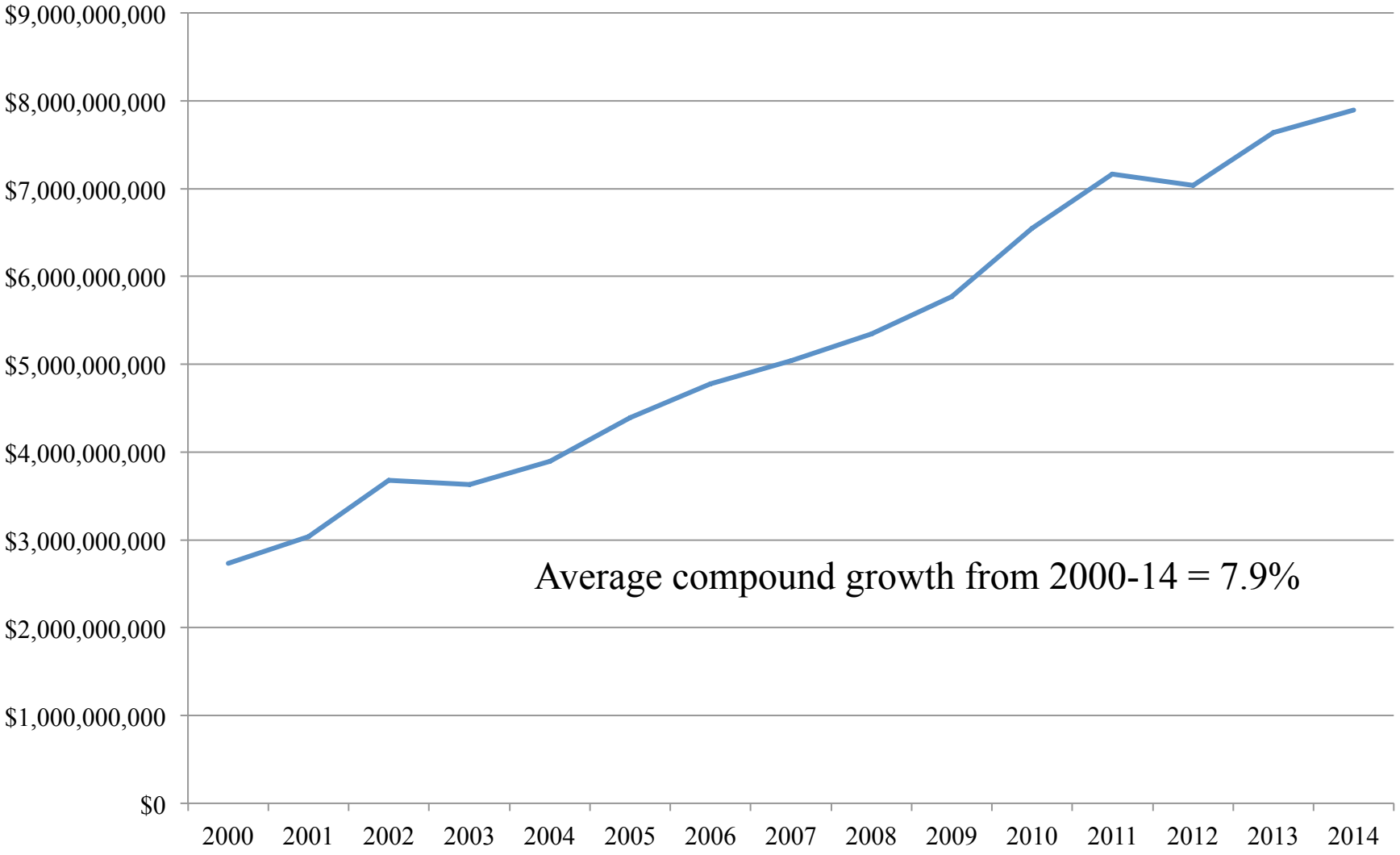
- 2016-18 biennial GF base budget about $37.5 billion. Available GF resources (balances, revenues, transfers) of about $40.0 billion assuming current forecasted growth rates (i.e., $2.5 bil. above base budget). Additions to the base budget could include:
  - Initial K-12 rebenchmark ($341 million – net of $47 mil. VPI non-participation); Final update includes changes to: LCI, enrollment, VRS, lottery and sales tax revenues.
  - Medicaid inflation and utilization (5% growth=$600 mil; 7% growth=$850 mil)
  - Enhanced funding for locally mandated programs, such as K-12 public education.
  - Higher education base funding increases, more student aid, other initiatives.
  - Other health & human service increases: e.g., CSA, behavioral/mental health.
  - Additional debt service for already authorized debt. New debt capacity $550 mil./yr. Cash for capital spending?
  - Increase state employee and faculty salaries and benefits, including health care costs. Restore selected agency cuts?
  - Accelerate full funding of VRS? Current projected 2016-18 teacher rate of 14.66% represents 90% of full contribution rate needed. One-time cash infusion?
  - New initiatives, such as "GO Virginia"?
  - Tax policy changes such as repealing the accelerated sales tax payment ($200mil.); or new/expanded economic development incentives?

What Has Held Back State Funding?

Slower State GF Revenue Growth

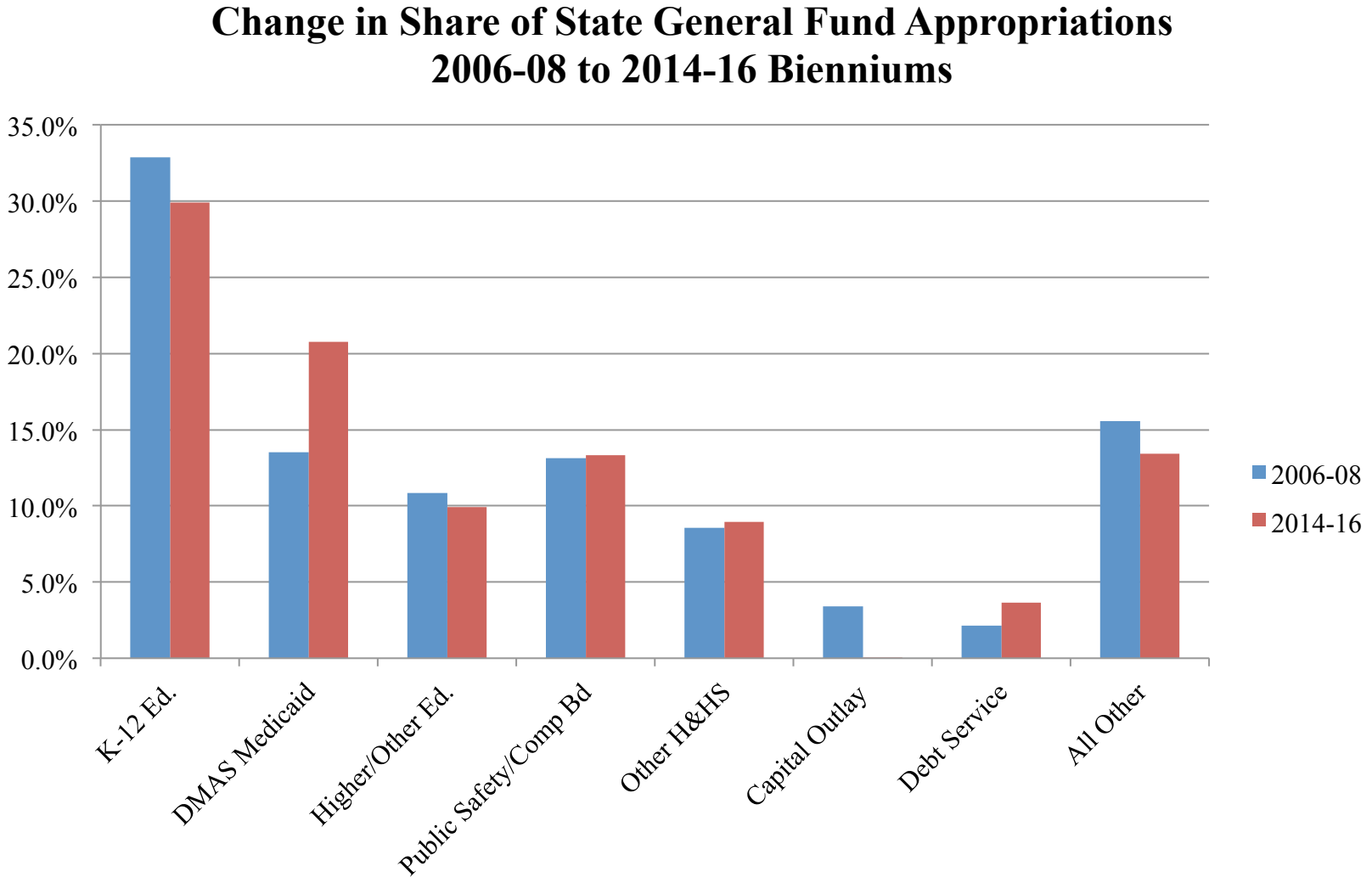
Years	Avg. GF Revenue Growth
1990-1999	5.9%
2000-2008	5.7%
2009-2015	1.9%

Total Medicaid Expenditures as Recorded in the Commonwealth Accounting and Reporting System (CARS)

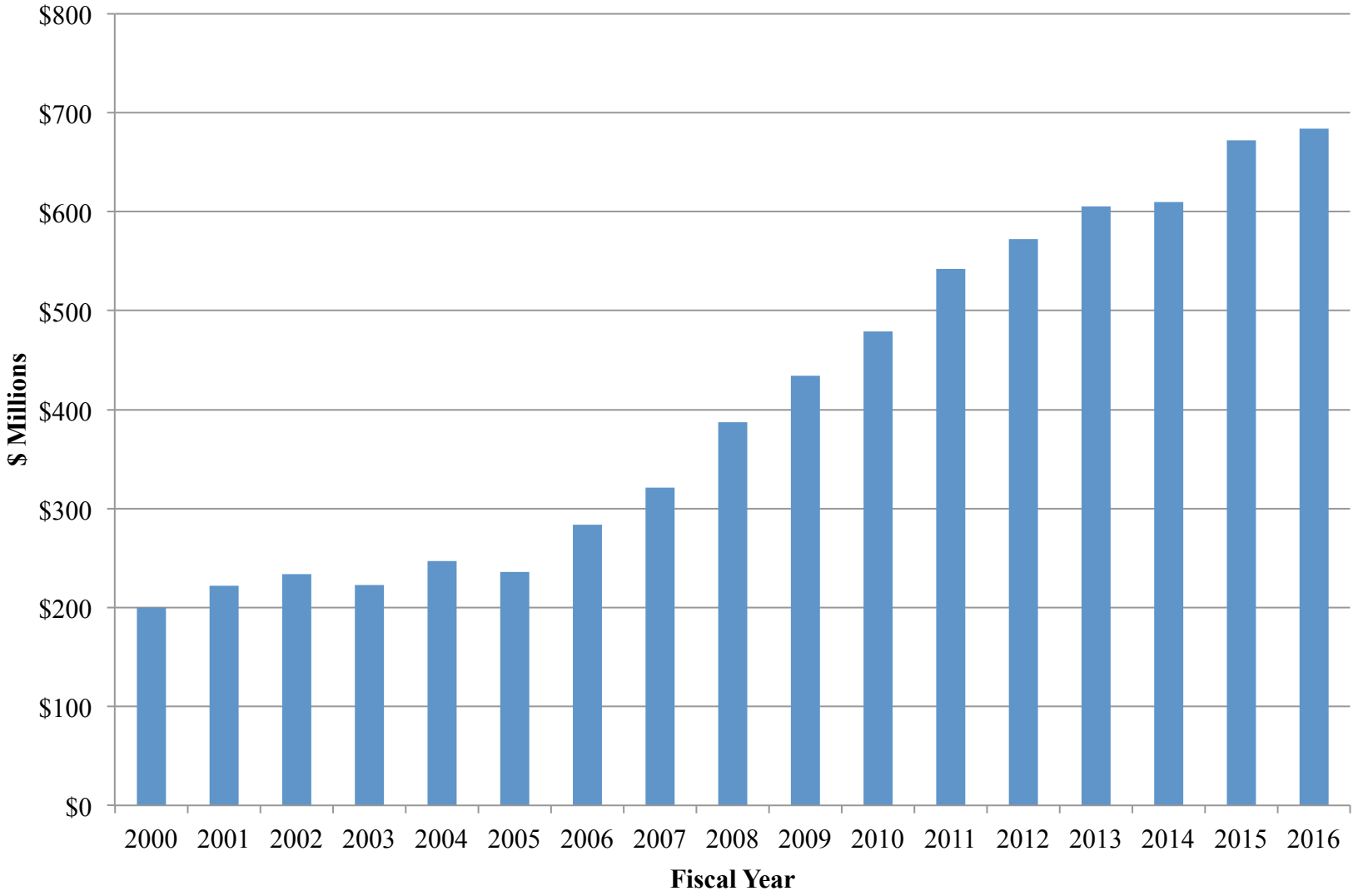


Source: DMAS Statistical Record

Medicaid Spending Crowding Out Other State Spending Priorities



Growing State GF Debt Service



Tax Changes Reducing Biennial State GF Revenues by $3.1 Bil.

	Enacted/Amended	Biennial ($ Mil.)
Age Subtraction (net of 2004 means testing)	1994 and 2004	($581)
Car Tax Reimbursement	1997, 2003	($1,900)
Subtraction for UI/Military/Gov't Empl	1999	($74)
Historic Rehab Tax Credit	1999	($152)
Coalfield Employment Tax Credits	2000	($68)
Low Income Tax Relief	2000, 2004, and 2007	($412)
Land Preservation Tax Credit	2003	($200)
Impose 2.5% Sales Tax on Food	2004	($1,094)
Estate Tax Repeal	2009	($280)
Other Tax Changes since 1999	1999-2014	($182)
State Tax Reductions since 1994		**($4,942)**
Sales Tax Presence in Virginia Amazon	2012	$41
Sales tax on satellite TV equipment	2014	$19
Add 1/2 percent sales tax on non-food items	2004	$986
Recordation Tax Increase (net of 3 cents to transp.)	2004/2007	$210
Tobacco Tax Increase	2004	$285
Close 2 Corp. Tax Loopholes/Eliminate ST Exem for Pub. Svc. Co.	2004	$286
State Tax Increases since 1994		**$1,827**
Net State Tax Change Since 1994		**($3,115)**

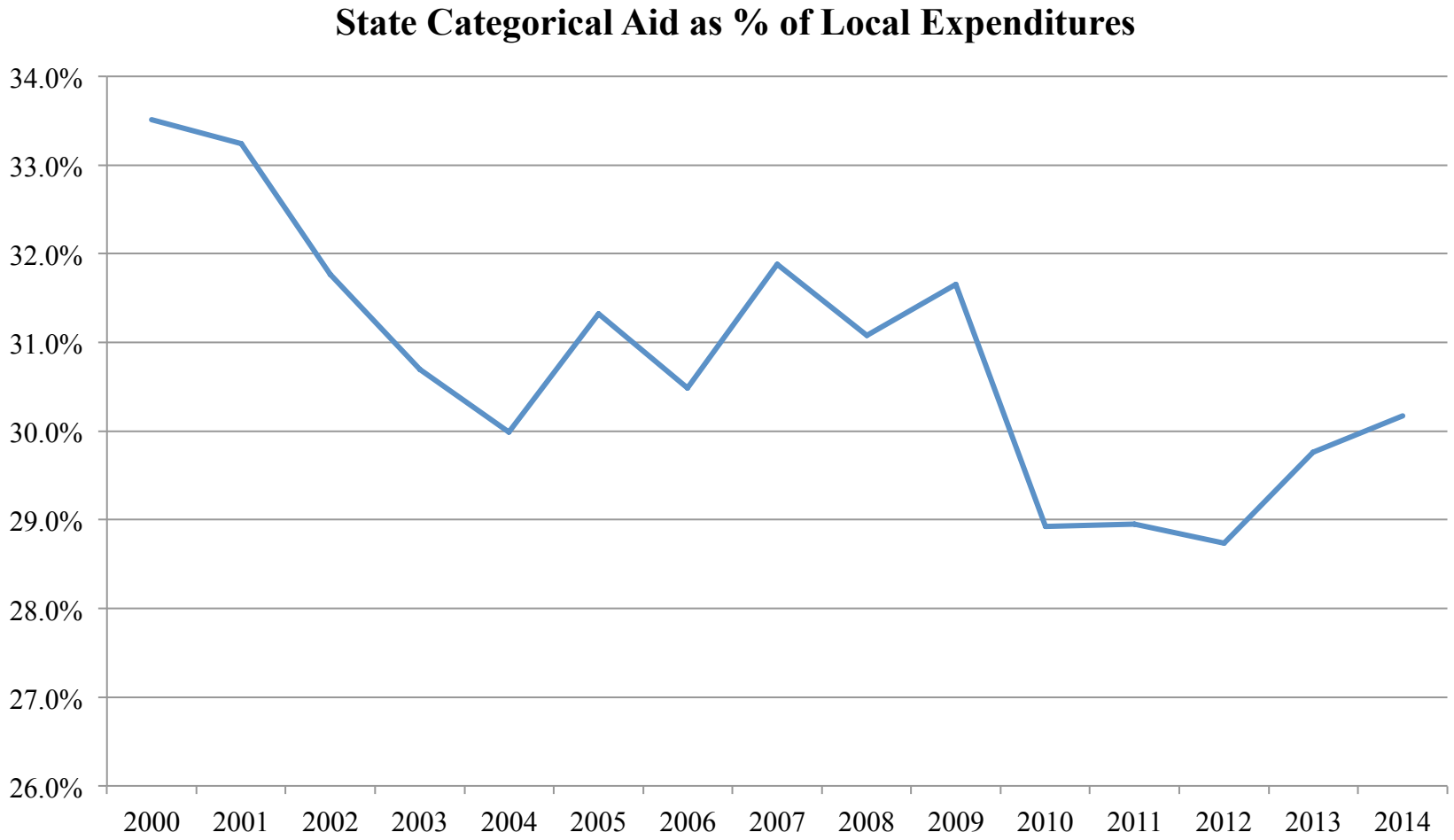
Source: Senate Finance Committee Retreat, Revenue Outlook, Nov. 20 , 2014

Overall State Aid to Localities Declining as a Percent of the GF Budget

GF State Aid to Localities ($ Mil.)

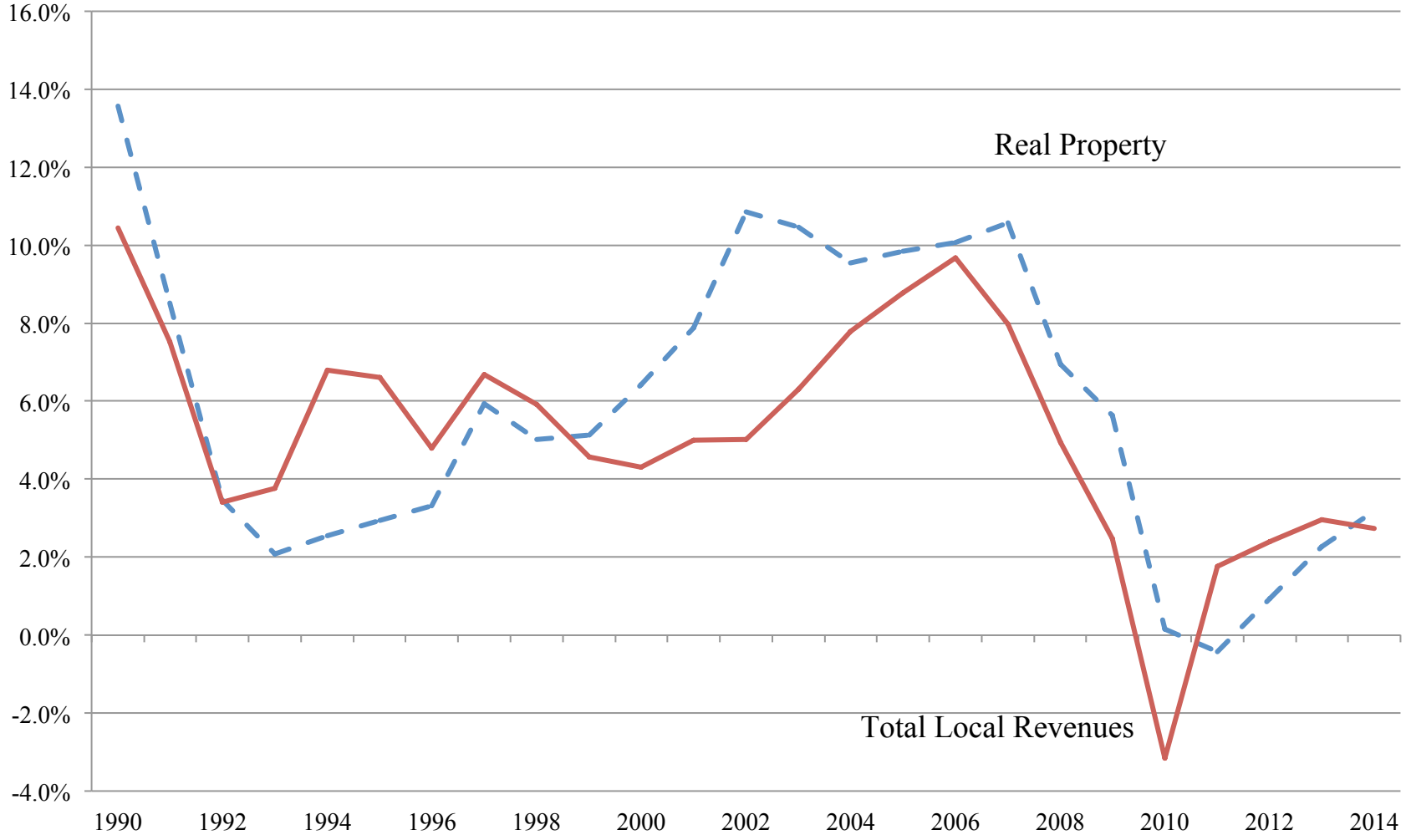
	FY 2009	FY 2012	FY 2014	FY 2015	FY 2016
Direct Aid to K-12	**$5,607.6**	**$4,903.1**	**$5,240.3**	**$5,405.4**	**$5,560.3**
Health and Human Services	**888.4**	**822.7**	**791.7**	**810.1**	**846.8**
CSA	*299.7*	*245.2*	*217.2*	*217.4*	*217.4*
Community MH/MR Services	*249.4*	*269.0*	*269.3*	*287.3*	*317.1*
Local Social Services Staff	*117.4*	*111.4*	*115.3*	*112.1*	*114.4*
Community Health Programs	*117.6*	*109.3*	*107.2*	*110.6*	*115.1*
Welfare Services and Programs	*104.3*	*87.8*	*82.7*	*82.7*	*82.8*
Public Safety	**734.3**	**670.0**	**687.9**	**713.2**	**704.2**
Local Sheriffs Offices	*406.1*	*396.9*	*411.3*	*431.2*	*436.0*
Local Police Depts HB 599	*197.3*	*172.4*	*172.4*	*172.4*	*172.4*
Local Jail Per diem	*80.1*	*54.5*	*59.4*	*63.9*	*50.1*
Assistance for Juvenile Justice	*50.8*	*46.2*	*44.8*	*45.7*	*45.7*
Constitutional Officers	**$155.3**	**$143.8**	**$145.8**	**$152.4**	**$152.5**
Car Tax	**950.0**	**950.0**	**950.0**	**950.0**	**950.0**
Aid-to-Locality Reduction	**(50.0)**	**(60.0)**	**0.0**	**(30.0)**	**0.0**
Total Local GF Aid	**$8,285.6**	**$7,429.6**	**$7,815.7**	**$8,001.1**	**$8,213.7**
Total GF Appropriations	**$15,943.0**	**$16,556.9**	**$17,705.2**	**$18,240.2**	**$18,764.2**
	52.0%	**44.8%**	**44.1%**	**43.9%**	**43.8%**

State Support For Locally-Administered Programs Has Fallen Over Time



Source: APA Comparative Reports on Local Revenues and Expenditures, Fiscal Years 2000-2014

Localities Only Beginning to Recover from Real Estate Recession



Note: real property tax rate changes from FY 13-15: 20 cities increased, 2 decreased; 57 counties increased, 7 decreased .

Since Recession, Local Revenues & Expenditures Have Not Kept Pace with Inflation* / Population Growth

	FY 2009 - FY 2014 Growth Comparison					
	Locally-Generated Revenue	State/Federal Revenue for Localities	All Revenue for Localities	O&M Expenditures	Population	Population/ Inflation*
VA Cities	**3.9%**	**-1.4%**	**1.7%**	**0.1%**	**3.7%**	**14.2%**
VA Counties	**9.0%**	**6.8%**	**8.2%**	**8.3%**	**5.3%**	**15.8%**

* Inflation as measured by the CPI grew 10.5% from FY 2009-14

2016-18 Budget Issues of Significance to VCOPPA

- **Increased CSA Pool Fund expenditures:** $32.8 mil. to cover CSA costs (special ed. day placements), enrollment growth, and $19.8 mil. savings that did not materialize from a new waste, fraud, abuse analytical system.
- **Increase Foster Care and Adoption Rates (DSS):** $1.4 mil. GF/NGF each year for anticipated increases in the Title IV-E Foster Care and the Adoptions programs due to a two percent cost of living increase in foster family home rates and clothing allowance.
- **Implement Fostering Futures Initiative:** Funding for the Virginia Department of Social Services (VDSS) to implement the provision in the federal Fostering Connections to Success and Increasing Adoptions Act of 2008 (FCA) which permits states to extend foster care supports and services to youth who turn 18 while in foster care, until the age of 21.
- **Eliminate the local match responsibility for Residential Treatment Center (Levels A/B and C) and TFC Case Management Services for CSA children on Medicaid:** Increase GF by $10.3 mil. per year. Transfer funding responsibility from CSA to DMAS.
- **Fund education costs for students placed in residential facilities not using local CSA processes.** $21.5 mil. to cover costs of education for students placed in residential treatment facilities using Medicaid funding. Not viewed as a long-term solution.
- **Waive local match on CSA non-mandated funds:** $21.0 mil. to eliminate the local match for non-mandated children. The intent is to serve as an incentive for localities to utilize all their non-mandated funding and serve a greater number of children.
- **Expand Services for Young Adults:** $7.4 mil. proposed for eight new Coordinated Specialty Care teams to provide mental health and substance abuse treatment services to 600 adolescents and young adults ages 16-25 with serious behavioral health conditions.

Conclusion

- Improving state revenues will allow the state to begin restoring spending cuts of recent years.
  - Education funding the highest priority of the Governor.
  - Behavioral/Mental Health/Geriatric funding issues also likely to be a priority (e.g., DOJ settlement agreement/IDD waiver design, Hancock Geriatric).
  - Forecasted 2016-18 Medicaid growth still unknown and will help determine funding levels for other priorities.
- Continuous pressure on Virginia by federal CMS to diversify from residential care to integrated care settings in the least restrictive environments.
- If the Governor proposes Medicaid expansion, with GF savings paired with new initiatives, General Assembly will likely produce a major re-write of the budget.
- Not clear what priority some CSA issues have. Have to do's include additional funding for enrollment cost increases and growth and unmet savings; and increasing foster care and adoption rates. Implementing the fostering futures initiative has been an administration priority Other agency requests will have varying levels of priority.

Appendices

Virginia Is a Wealthy, Low Tax State, With Higher Reliance on Locality Taxes

	2012 JLARC Ranking	2015 JLARC Ranking
Per capita personal income	8	10
State and local *revenue* as a percentage of personal income	49	49
State and local *taxes* as a percentage of personal income	43	45
Per capita state taxes	34	36
Per capita local taxes	13	15
Individual income taxes as a percentage of state and local tax revenue	7	6
State motor fuel tax rate rank	37	46

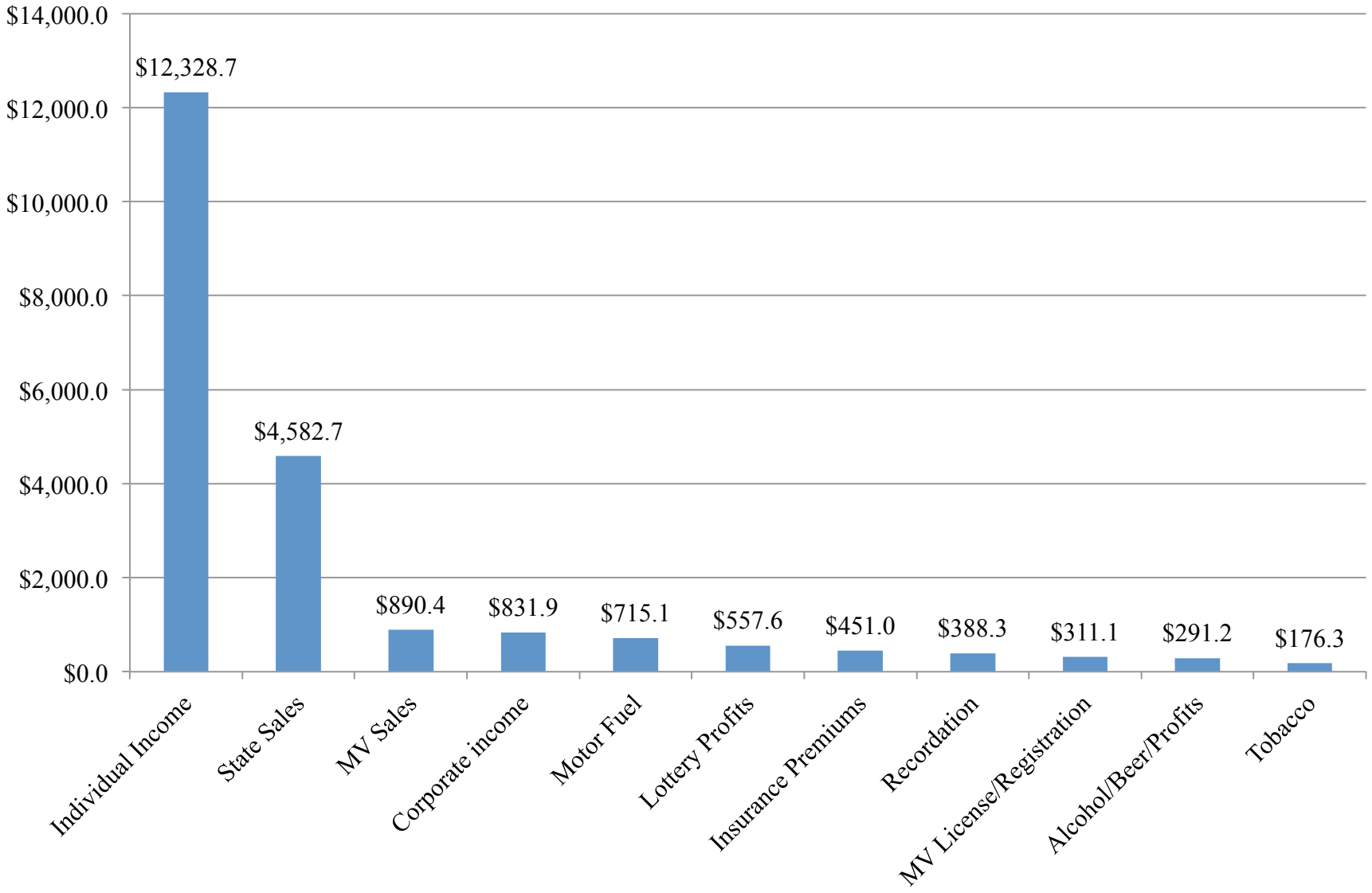
Source: Virginia Compared to Other States, JLARC, 2012, 2015 Editions

Virginia Ranks Well Below the National Average in Spending Despite Its Wealth

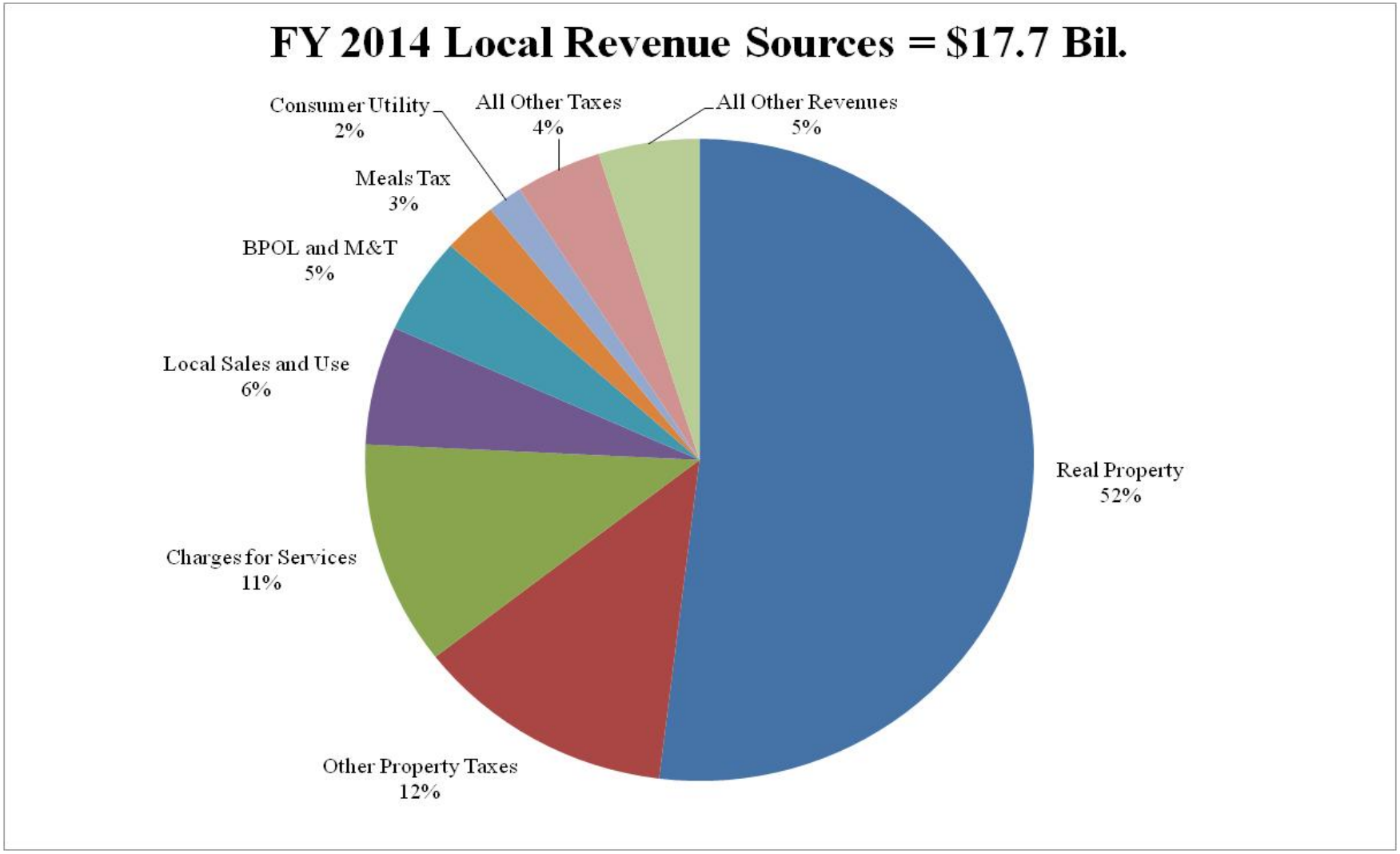
	2012 State Rank	2015 State Rank
Per Capita Personal Income	8	10
Per Capita State Expenditures	32	27
State Per Pupil Funding	35	41
State and Local Per Pupil Funding	17	26
Average Salary of Public School Teachers	28	35
Per Capita State and Local Road Expenditures	38	28
Per Capita Medicaid Expenditures	47	48
Average Annual In-State Tuition and Fees at Public 4-Year Institutions	12	11

Source: Virginia Compared to Other States, JLARC, 2012, 2015 Editions

FY 2015 Major State Revenue Sources ($ Mil.)



Local Revenues Dominated by Property Taxes



Note: "All Other Taxes" includes, transient occupancy, MV license, recordation, bank stock, tobacco, admission, severance, franchise license, other

Source: Auditor of Public Accounts Comparative Report of Revenues and Expenditures

Virginia League of Social Services Executives

2015 VCOPPA Symposium

November 11, 2015

Virginia League of Social Services Executives

JLARC Medicaid Eligibility Report

JLARC estimates that $21-38 million in Medicaid benefits have been distributed to non-eligible individuals in the past year.

The backlog of Medicaid renewals is primarily to blame:

- Significant increase in applications are part of the reason for the backlog.
- Under staffed local departments also contribute significantly.
- 50% of the problem attributed to 6 localities.
  - 5 of these 6 have the lowest staffing levels relative to caseload.

Virginia League of Social Services Executives

JLARC made four recommendations:

- Have eligibility workers check electronic sources to verify lack of income and assets.
- Have VDSS revise the funding allocation formula.
- Have DMAS proactively seek recovery from estates.
- Seek authority from the General Assembly to use the Medicaid CPU to address the backlog.

Virginia League of Social Services Executives

Legislation

- On the lookout for the usual suspects.
- Budget:
  - *$5.6 million for additional CPS workers.*
  - *Elimination of Medicaid local match.*
  - *Safe Families.*
  - *Fostering Futures*
- Kinship Diversion legislation.

VCOPPA Symposium

Virginia Network of Private Providers, Inc
Jennifer G. Fidura
11 November, 2015

Legislative Agenda 2016

- **Support the goals for the Redesign of the ID/D Waivers:**
  - **To offer an array of service options to meet the diverse needs of the ID/D individuals who qualify for one of the three Waivers.**
  - **To encourage supports in the most integrated settings possible by adequately funding those services which will help achieve that outcome.**
  - **To plan, through the person centered planning process, supports that meet but do not exceed the needs and preferences of the individual.**

- Work with our partners in the Executive Branch, VACSB, VaACCSES and other provider groups to identify the costs which will be associated with the likely implementation of the revised federal standard for overtime pay.

- Coordinate with DMAS and DBHDS to ensure that we preserve the definition of “independent contractor” for Sponsored Residential Families while providing all necessary protections for the individuals supported by obtaining criminal background checks.

- Partner with other advocates to request funding to mitigate the concerns of the families who have waited the longest for a “DD Waiver slot” when the waiting lists for the Waivers are combined into one needs based list.

Older Youth in Foster Care

- "Fostering Futures": program under the federal Fostering Connections Act to broaden services & supports for youth aging out of care up to age 21.
  - New financials are much more affordable: approx. $1.6 million in new GF over the coming biennium (not including similar amount of CSA "savings" transfer).
  - Limited to youth who would turn 18 on July 1, 2016 or later, so staggered approach helps to reduce cost.
  - Biggest benefits: continuum of housing options, true "transition to independence" focus.
  - Question comes down to maintaining the program in the final budget.

Juvenile Justice Reform

- RISE for Youth (www.riseforyouth.org): coalition in support of juvenile justice reform to shift towards family- & community-based supports.
  - DJJ has submitted a plan for Gov.'s consideration
  - RISE for Youth coalition goals are to close two remaining JCCs & reinvest in community continuum. Any locked facilities for youth should be small, therapeutic, & close to home communities
  - Potential adjustments to CSA (cost-neutral to localities) to spark use of non-mandated funds for evidence-informed programs for youth in JJ system/youth at risk of LTS/ expulsion