



The Senate of West Virginia
Charleston

January 2, 2023

Dr. Jeff Coben
Interim Secretary
West Virginia Department of Health and Human Resources
One Davis Square, Suite 11 East
Charleston, West Virginia 25301

Dear Interim Secretary Coben:

On behalf of the Senate, please accept our congratulations and well wishes for your success as you embark on the responsibilities and challenges of your new position. As you are aware, the Senate is deeply concerned about the current state of numerous programs housed within the West Virginia Department of Health and Human Resources (DHHR) and is committed to doing anything in its power to make and facilitate marked improvements, particularly in the area of child welfare.

Over the past six years, the West Virginia Legislature has allocated more funding for child welfare than at any previous point in West Virginia history. In that same timeframe, the Legislature has also passed two major child welfare reform bills and several targeted pieces of legislation to help the DHHR fix our broken Child Protective Services (CPS) system. Unfortunately, DHHR has not made adequate progress for our children and families. In some areas, we have even lost ground. Making matters worse, the Legislature has struggled to secure answers from DHHR on how to specifically solve these grave problems. DHHR has not even been forthcoming with information about what the difficulties are, and we generally must depend on other stakeholders to inform us of critical issues.

On December 8, 2022, Senate Judiciary Chairman Charles Trump sent a letter to your predecessor highlighting specific problems in our Eastern Panhandle. Chairman Trump had previously asked for information in the Joint Committee on Government and Finance during December interim committee meetings. Despite the dire situation, we have not received any response. This is just one example of DHHR's unwillingness or inability to be responsive.

Despite this, we remain optimistic. Since you, Dr. Clay Marsh, and General James Hoyer have taken the helm at DHHR, there have been some long overdue and positive incremental steps that are applaudable. As you develop these approaches, we appreciate that you have reached out to key members of the Legislature's staff that have experience in this area of policy. We have to keep working toward

collaborative solutions. We all recognize that while facilitating retirees coming back to work in CPS, providing increased sign on bonuses, and engaging in more CPS recruitment initiatives are all needed, these steps alone will not create the type of transformation that must occur.

Frankly, we have a long way to go to remedy our child welfare issues in the Eastern Panhandle and other parts of our state, and West Virginia, more broadly. These are problems that must be solved. We have been stuck in neutral on the side of a hill. Doing nothing is causing us to go the opposite direction of where we want to be. We have to move past just talking about how broken CPS is and actually fix it. This is not something that can wait.

In the spirit of working together, please review the following policy options. We would like for DHHR and the Bureau for Social Services to assess the cost, timeframe for implementation, and risks associated with the following policies. We also want DHHR and the Administration to come forward with its own ideas in a similar cost and implementation breakdown. Let's map it out and make it happen.

CPS and Child Welfare Policy Options

Short Timeline:

1. Increase regional pay differential via locality pay to properly compete with Virginia and Maryland in the Eastern Panhandle. A more proper analysis is needed, but an immediate 20% is warranted given the crisis. This can come from existing personnel service funds at DHHR. This must include starting pay, as well as increases for existing CPS workers. Governor Justice made a good step in this direction earlier this year by approving pay increases for child workers, but the DHHR blunted the effectiveness of this initiative by applying it only to existing workers. Because the new pay scales were not applied to new workers, none came.
2. Ensure transparency with child welfare issues. The number of issues heard by legislators concerning child welfare dramatically underrepresents what is occurring. In recent years, there has been a reluctance to transparently notify policymakers when a child in state custody dies, systemic abuse/neglect occur in a provider setting, or other calamities occur. As recently as the December Legislative interim meetings, DHHR was asked in committee if major systemic abuse had occurred in out-of-state facilities triggering children to be removed this year. They answered that it had. While the details were not fully exposed in committee, that is not an ideal way for the public or policymakers to be informed of major system failures concerning children in state custody. This model would be based on a military management tactic called Critical Information Requirements.
3. Reallocate vacant personnel service funding to starting salaries for CPS workers. Previous 15% increase, as directed by the Governor, applied to only existing workers. Another 10-15% should be infused statewide. This can come from existing personnel service funds at DHHR.

Intermediate Timeline:

1. Social Services needs to be required to develop a CPS position reallocation plan that adequately serves population. The current population base of some counties is significantly underserved. It is recommended that total population serve as a base level factor in allocations based on current number of CPS staff allocations. For counties that have extraordinary needs, a factor would be incorporated to enhance the base of CPS workers in that county. This proposal would not call for any county to receive less than they currently have without DHHR attesting that such a decrease

would not impact services in that county. To make up the difference, additional CPS positions would be added to current totals.

2. Shift more funding to CPS personnel services lines to increase denominator of CPS positions in underserved counties.
3. Expand foster care ombudsman authority to apply to abuse/neglect investigations, including monitoring of critical staffing issues. Current ombudsman authority only applies once a child is in state custody.
4. Institute annual survey of key stakeholders on performance of CPS by county that are published publicly.

Long Timeline:

1. Streamline responsibilities of CPS workers to only most essential functions and outsource other jobs/ responsibilities to other staff or private sector. The Bureau for Social Services will be tasked with assessing workflows of other states as part of this streamlining and refocusing current workforce.
2. Implement strategy that allows front line investigations to be conducted by staff specialized for investigations who can then hand off the case, if appropriate, to someone trained in social work services. This would expand the job pool to include former law enforcement and help address DHHR's terrible timeframes on initiating investigations.
3. Rebase caseload to a formula that considers an individual child a case or weights certain types of complicated cases in a manner that it is counted as more than a single case. Current caseload formula is antiquated and does not take into consideration complexity of modern casework.
4. Completion of the workload study for CPS was a previous recommendation discussed with Circuit Judges in the Eastern Panhandle. This study was triggered by a House Resolution in 2021. The report was significantly delayed but was finally presented this month. Unfortunately, this study failed on several levels to tell us much that was new or to give a clear answer on how to solve these ongoing problems. DHHR either needs to have the workload study refurbished or obtain answers through different means. We need the following:
 - a. Critical questions that need to be addressed are what is an actual case in the caseload ratio? Some states have moved away from the entire family being a case due to growing complexities in family dynamics driven by the drug crisis.
 - b. Strategies to get ahead of CPS staffing shortages that regularly plague specific areas around the state. Standardized post-employment surveys, market studies to index pay scale, and strategies to realign worker allocation are three major topics.
 - c. Workflow efficiency: One key example of this would be handing off pre-adoption work to a specialized adoption worker and take the paperwork burden off the CPS case worker.
 - d. CPS specialization: Some counties have CPS workers specialize in courtroom representation and field investigations and then those workers are deployed in that manner. Other counties have CPS workers conduct the full process of a case from start to finish.
5. Development of county/regional-based mental health treatment menu and service inventory. There are two purposes for this tool. One is to ensure that families, social workers, courts, etc., are aware of supports. Two, development and utilization of a county/regional-based service network adequacy tool that will serve to mandate a certain threshold of service in each region of the state.

6. Mandate development of a child trauma predictive model. This tool would use existing data available to the state to trigger preventative supports to families that are in crisis before a trauma occurs that triggers CPS referral. This model has been scoped out for a few years, but commitment and execution has waned in DHHR. West Virginia has a higher percentage of its children in foster care than any other state in the United States. Clearly, a part of this problem is the lack of services that are being provided to families to try to keep them together where that is possible. Where that is possible, keeping families together should be the goal of the system.
7. Foster parent portal to improve communication and drive accountability. This tool, in addition to improving communications, would be used to quantify complaints from foster parents when CPS case workers and assigned child placement agencies fail to respond to critical questions from foster parents. Currently, voluminous numbers of complaints are made with the ombudsman, legislators, and other policy leaders, but there is no way to properly track the failure of workers, counties, districts, or contracted providers of the state. As such, these problems continue in a cyclical pattern that goes unresolved.
8. Utilize providers, counselors, or social workers in schools to help identify abuse/neglect and prevent trauma.
9. Require CPS to conduct an investigation any time law enforcement, a teacher, or medical professional makes a referral, with follow up to the individual referring on outcomes.
10. Provide law enforcement, providers, and school staff with alternative social work support referral options for children whose families may be struggling but do not rise to the level of abuse and neglect requiring the removal of children from their homes.
11. Develop reporting structure to allow monitoring of critical CPS functions, and youth and family service functions, at the supervisory unit level to make sure caseloads are not overwhelming, staff is not overexercising authority to take custody of children or remove children from biological and foster families, visits are being made, and cases are being properly vetted.
12. Out of State and Inappropriate Placements
 - a. Funding is the most critical barrier to resolving the OOS and inappropriate placement issue. The West Virginia Legislature and Governor have allocated more funding to health and human resources generally, and child welfare specifically, over the past several years than at any point in West Virginia history. West Virginia must fully explore what funding can be redirected from current allocations to develop child acute mental health infrastructure in communities and sustain it. There must be a mixture of capitalization investment and commitment to the mental health infrastructure long term. This can be accomplished through the following strategies:
 - i. Realignment of Medicaid funding over that from the Bureau for Social Services to cover expenditures for children placed out of state to maximize federal funding from the Centers for Medicare and Medicaid Services (CMS). This will generate capitalization and operational funding.
 - ii. Assess for the purpose of maximizing IV-E funding opportunities for children placed OOS to maximize Federal funding from the Administration for Children and Families (ACF). This will generate capitalization and operational funding.
 - iii. Realignment of funding that is otherwise being spent out of state to in-state infrastructure. This will generate operational funding.
 - iv. Repurpose Bureau for Behavioral Health investment from adult forensic and civil commitment group homes to child mental health facilities. This will generate capitalization funding.

- v. Partner with private providers, nonprofits, and the Congressional delegation to seek federal grant opportunities for capitalization funding. In particular, the Bureau for Behavioral Health should evaluate all available grant funds and future grant funding opportunities for this purpose as a top priority.
 - vi. Partner with private and non-profit entities so they are comfortable that West Virginia is committed to this long-term investment to encourage private and non-profit investment. West Virginia has a great need for these services. Given NAS rates and other trends in trauma, it can be projected that need for acute care services will continue to grow. In as far as foster children are categorically eligible for Medicaid, private providers will have a long-term stable payment source and, ultimately, a return on their capital investments.
 - vii. Explore a modification to West Virginia Medicaid's current 1915(c), IDD Waiver, or develop new 1915(c) waiver to serve children that have diagnosis of IDD/low IQ and exhibit acute behavioral challenges. This strategy would maximize Federal CMS funding. This will generate capitalization and operational funding.
 - viii. Modifying the Medicaid State Plan to allow for payment to OOS child residential facilities. This strategy is only a bridge until infrastructure can be built in state to service the need. This approach would maximize Federal CMS funding. This generates capitalization and operational funding.
- b. Build Out Multifaceted Placement Infrastructure
- i. The types of services needed can be categorized in several different ways. West Virginia needs services for children with acute and long-term psychiatric issues. West Virginia also needs services for children that have intellectual and/or developmental disabilities. Within each of these buckets are myriad age, gender, diagnosis, and functionality categories that must be carefully planned for. The four major categories that need to be built out are: 1) infrastructure to be able to provide services to families in their homes; 2) psychiatric residential treatment facilities; 3) small group homes for children with IDD; and 4) expansion of acute behavior emergency shelters.
- c. Regulatory Reform
- i. Reduce Staff Ratio Requirements: Modify the PRTF staffing ratio for clinical staff, depending on acuity of the children being served. Other types of staff could supplement this shifted ratio. This issue requires more research but has been referenced by providers in West Virginia.
 - ii. Use LPNs for RN breaks: Change regulatory requirements, at least for psych hospitals (IMD's) and other mental health facilities, to allow LPNs to be on each unit instead of RNs on a 24-hour basis. The current requirement means that if you have a unit with a registered nurse, and if he/she needs a break, you must have an RN replace them. This requires two RNs per unit. While the need for RNs is understandable, this reduced requirement would allow facilities to meet demand more easily.
 - iii. Regulatory Review Study: Request analysis by the Child Care Association, Hospital Association, and Behavioral Health Association, to identify specific regulatory reforms that would facilitate build out of additional psychiatric and IDD behavioral health placements for children.

- iv. **Elimination of CON Criteria:** There has been some question as to whether all provider functions envisioned in this proposal meet requirements that would otherwise trigger a time-consuming certificate of need process. It is proposed that CON be eliminated for these services entirely.
- d. **No Eject, No Reject Policy Expansion**
 In 2019, the West Virginia Legislature passed a bill that prevented child residential treatment facilities from rejecting children from placement or ejecting children from placement unless certain criteria were met. This policy was designed to end what is called “cherry picking,” an instance where a provider only takes children that are easier to care for to mitigate need for additional staff. This policy should be expanded from child residential providers to other provider groups that hold themselves out in license as being able to care for certain criteria of behavior. Appropriate workarounds would be built into this policy for safety purposes.
- e. **Managed Care Policy**
 - i. **Social Service Capitation:** Currently, the Mountain Health Promise vendor is only responsible for Medicaid expenses related to a foster child. This creates a dynamic where the managed care organization may have a vested financial interest in shifting patients to placements where the managed care entity does not have to pay. This policy has been delayed due to missed deadlines on the Integrated Eligibility System (IES), which includes the foster care case management and financial accounting infrastructure. An analysis should be conducted of this contract to determine if the IES vendor has liability from this three-year delay in implementation. As soon as can be implemented, the Mountain Health Promise vendor should be required to cover capitation of the Bureau for Social Service and Medicaid expenditures, as was originally envisioned by the Legislature.
 - ii. **Performance Based Measures on OOS Placements:** The Mountain Health Promise vendor should be held financially accountable when a child is placed out of state or in an inappropriate alternative placement. Performance based measures are a tool that the Centers for Medicare and Medicaid Services allows states to use to encourage certain actions beyond the traditional capitated incentive arrangement. This strategy could also expedite implementation of these overarching range of policies.
- f. **Limited Liability**
 Liability of providers caring for children remains a major barrier. Liability insurance has been identified as a major avoidable cost by the provider community when comparing themselves to peers around the country. Reducing operational costs are a benefit for the health of the provider infrastructure generally. In addition, limited liability legislation may eliminate barriers that keep providers from expanding services or coming into West Virginia’s market.
- g. **Home and Community Based Service Delivery**
 Placements in institutional settings must be the last resort for all children. Services in a familial placement in the child’s community should be the goal in every case where a child or their family have need. While there are certainly instances where a child may need highly specialized services in a mental health setting, such supports must be the last resort, and as short in duration as possible, to ensure the child’s proper treatment, their own safety, and the safety of those supporting the child. Despite significant momentum and progress starting in 2014, and commitment to the Department of Justice in a Memorandum of Understanding in 2019, DHHR has not been able to build out the

infrastructure necessary to achieve the above stated goals. As such, the following solutions are recommended:

- i. Statutory Service Mandate: Codification in West Virginia Code that in-home and community-based services must be available, as appropriate, for children with serious mental health conditions and/or IDD. Such may already be interpreted in the West Virginia Foster Children Bill of Rights (§49-2-126), but clarification of such is warranted.
- ii. Annual Report: Annual report to the West Virginia Legislature outlining the availability and utilization of preventative services and in-home and community-based services, for children with serious mental health conditions and/or IDD. This report must include a county/regional level provider availability analysis. This report should include statistics on how many children from each county/region are placed out of home because of mental health/IDD related behavioral issues.
- iii. Budget Prioritization: Require that DHHR reassess budgetary priorities to ensure that funding is redirected to the adequate development and operation of preventative and in-home and community-based services for children with acute behavioral issues across West Virginia. This report should include recommendations on what lower priority service/program expenditures are recommended to be discontinued across DHHR to ensure ongoing available funding for this purpose. The intent is to ensure a flat overall DHHR budget but to expand these specific services and supports.

As we hope you realize, West Virginia's children and families have suffered from critical failures in the agency you now lead. A lot of work has gone into fixing these problems, but we must have outcomes. We are pleased the Administration has joined the Legislature in realizing the status quo cannot continue and we look forward to working collaboratively on solutions moving forward.

Thank you.

Sincerely,

Craig P. Blair, President – Lieutenant Governor
Senator Tom Takubo, Majority Leader
Senator Eric J. Tarr, Chairman, Committee on Finance
Senator Charles S. Trump IV, Chairman, Committee on the Judiciary