HEALTH WEALTH CAREER

THERAPEUTIC FOSTER CARE/HOME CARE TRAINING TO HOME CARE CLIENT

ANALYSIS AND RECOMMENDATIONS REPORT

SEPTEMBER 21, 2018

Arizona Health Care Cost Containment System

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EXECUTIVE SUMMARY

Home Care Training to Home Care Client (HCTC) services is the State of Arizona's (Arizona's or State's) model of therapeutic foster care (TFC), provided in a community home/family-like setting to children/youth and adults, primarily through the State Medicaid program. Throughout this report, Arizona's model will be referenced utilizing the term HCTC. TFC will be utilized when referencing direct language in regulation or rule, national models and in describing the terminology used in other states. As a result of reported challenges in accessing HCTC services, and inconsistent management across managed care organizations (MCOs), the Arizona Health Care Cost Containment System (AHCCCS) engaged Mercer Government Human Services Consulting (Mercer) to review HCTC in Arizona and evaluate national and state best practices to identify opportunities to improve the delivery of services in Arizona.

When administered effectively, HCTC services allow individuals with complex behavioral health (BH) needs to be safely and effectively treated and supported in a community home/family-like setting. This setting is required to be a licensed foster home certified in HCTC. Treatment services provided as part of HCTC include personal care, psychosocial rehabilitation, skills training and development, transportation to therapy or visitations and/or the participation in treatment and discharge planning. Currently, in Arizona, HCTC services are provided and managed through HCTC licensing agencies contracted with the MCOs responsible for managing BH care for Medicaid children/youth (including the Regional Behavioral Health Authorities [RBHAs] as well as the Children's Rehabilitative Services [CRS] MCO, which is responsible for managing BH services for children/youth with chronic and disabling conditions). For ease of reference when discussing the RBHAs and CRS MCO collectively, the term BH MCO will be utilized. MCO alone will then be utilized when referring to the broader AHCCCS MCO network and other state managed care organizational structures.

At the direction of AHCCCS, this report focuses primarily on HCTC services to children/youth (Arizona Department of Child Safety [DCS] and non-DCS involved). These services are delivered through Therapeutic Foster Homes (TFHs) licensed by the DCS Office of Licensing and Regulation (OLR). Providers are standard licensed foster homes who receive additional training and a special certification to provide HCTC.

Mercer reviewed current AHCCCS contracts, policies and guidance documents associated with the provision of HCTC services. Many of these documents have not been reviewed and/or updated in many years and should be evaluated both for current service delivery structure as well as models of care. Mercer conducted a high-level review of the rate structure and recommends exploring

opportunities to develop a rate that accounts for factors such as foster parent expertise or level of acuity for the child/youth. A deeper examination of the rate could determine whether this type of tiered rate may help improve access to services, especially for higher-acuity populations. Mercer recommends additional follow-up with researched state's applying tiered rates to gather additional information on the impact of those rates on their structure. Mercer evaluated the existing training requirements for HCTC, both in terms of minimum required training elements, and the current training curriculum. While minimum training requirements appear to be consistent with other states and national best practices, Mercer identified opportunities for restructuring the ongoing training and enhancement of State oversight of training curriculum development and administrations as well as the inclusion of BH-related topics developed by qualified clinicians.

Mercer then reviewed how BH MCOs operationalize and administer HCTC services, including how they authorize, manage and coordinate care for children/youth. In this review, inconsistencies were identified between BH MCOs in how the service is authorized and managed. Therefore, opportunities to improve uniformity in application of the service across BH MCOs are identified and described in the report.

To gather perspective on HCTC licensing, policy, service delivery, and outcomes for children and youth receiving care in HCTC foster homes, Mercer interviewed an AHCCCS-identified key stakeholder, the Arizona Chapter of Foster Family Treatment Association (AZ-FFTA). During this interview, a number of barriers were identified, as well as AZ-FFTA specific recommendations for resolving the barriers. Key themes included ensuring HCTC providers and DCS caseworkers are being proactively included as part of Child and Family Teams (CFTs) to ensure collaboration around treatment planning and permanency, establishing discharge plans as part of placement decisions, improving the public availability of information on medical necessity decision making by BH MCOs and standardizing such decision making, updating training, ensuring adequate training content and oversight, and streamlining the provider registration process. Mercer notes that some barriers identified may be based on mistaken perception of system rules, but these perceptions may influence how individuals interact with the system and, therefore, reflect actual barriers. Mercer's analysis has taken these barriers and recommendation into consideration and where any agreement arose is represented in the recommendations section of this report.

Finally, Mercer conducted a national best-practices literature review and an evaluation of other state models of TFC. While there is no standardized definition of or eligibility criteria for TFC, however Mercer's research did identify national attempts to standardize a definition for TFC. In addition, research on evidence-based practices (EBPs) identified a number of examples, with the following three service delivery models as most consistently referenced as EBPs of TFC. These include: Treatment Foster Care Oregon (TFCO), Together Facing the Challenge (TFTC) and Teaching Family Model (TFM).

Additionally, research indicates that training for TFC parents is a critical component of the service and is linked to positive outcomes including access to the service as well as permanency for foster children/youth. This is consistent with Mercer's findings throughout the report. Research also notes that ensuring foster parents feel supported is important for positive outcomes. Mercer's comparison

of other states' approaches for TFC delivery demonstrates variation in licensure, training, organization, delivery and payment of services. States use different names for the service, outline different goals for the service (e.g., step-down placement, short-term crisis setting or preventive service to reduce risk of out-of-home placement), apply EBPs to varying degrees and use different funding streams (e.g., Medicaid, state general funds, Title IV-E funding). However, there are common elements to the service such as some sort of medical necessity application, a licensure/certification requirement (in states that utilize foster parents to deliver elements of TFC), and some delegation of oversight to managed care, counties or child-placing agencies (CPA) depending upon the structure of the state.

Based on the results of its evaluation of the above-described materials and components of HCTC, Mercer developed a series of recommendations for consideration to improve and enhance the model in Arizona. These are organized around the following areas found either in Section 3, Recommendations, or throughout Section 4, Methodology and Findings, of this report.

- Minimum service expectations
- Prior authorization (PA) and concurrent review (CR) requirements
- HCTC training curriculum
- Licensure requirements
- Payment and Financing
- Outcome, process and capacity metrics that inform effective contract revisions
- Policy expectations
- Other

In addition to these discrete recommendations, Mercer identifies areas that AHCCCS should evaluate further, including network adequacy, service planning and rate development. Further analysis of these areas may yield additional enhancements to Arizona's HCTC model and improve the delivery of services to both children/youth as well as adults.

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BACKGROUND/PROJECT OVERVIEW

BACKGROUND

HCTC is Arizona's model of TFC. The Arizona HCTC services are available to children/youth (non-DCS and DCS involved) and adults as part of the BH service continuum of care. HCTC services are defined in Arizona as a short-term BH intervention that is an out-of-home level of care (LOC) service delivered in a community home/family-like setting by licensed and trained therapeutic foster parents as defined in Title 21, Chapter 6 of the Arizona Administrative Code (A.A.C.). Arizona offers HCTC to children/youth and adults as part of the Medicaid BH benefit continuum of care. By funding HCTC services through Medicaid, Arizona is able to draw down from the Centers for Medicare & Medicaid Services (CMS) matching dollars.

The goal of HCTC services is to create an opportunity for individuals with complex BH needs to be safely and effectively treated and supported in a community home/family-like setting. HCTC provides a structured treatment setting with 24-hour supervision and the provision of BH support services such as personal care, psychosocial rehabilitation, skills training and development, transportation to therapy or visitations and/or the participation in treatment and discharge planning. HCTC services assist and support individuals in reaching individualized service plan (ISP) goals and objectives.

Currently, HCTC services are provided and managed through HCTC licensing agencies contracted with one or more of the three identified RBHAs: Cenpatico Integrated Care (CIC), Mercy Maricopa Integrated Care (MMIC) and Health Choice Integrated Care (HCIC). Children/youth in foster care who have a chronic and disabling medical condition that qualifies for CRS are currently served by the CRS MCO for BH services.

Homes providing HCTC services to children/youth are licensed by the Arizona DCS OLR as professional foster homes. In addition to the licensing requirements from OLR, HCTC providers must receive additional training to be certified as a specialized foster parent, including completion of the Arizona Home Care Training Curriculum prior to providing services. Once all licensing and training requirements are met, each HCTC foster parent is required to receive a National Provider Identifier (NPI) from CMS, and register as an AHCCCS provider.[1,2] Across the above-mentioned

[1] AHCCCS requires a provider of HCTC services to adults to be a Department of Health Services-licensed BH Therapeutic Home. Because, as discussed below, this report is focused on services to children, the descriptions of licensing and other requirements are limited to those providers of services for children/youth.

requirements, there have been recent changes that are having an impact on availability of offered training, pool of qualified trainers, regulations and the management of HCTC requirements. Some changes (e.g., transition to a new standard foster care training curriculum, lack of HCTC train the trainer program, not allowing retroactive AHCCCS registration) have reportedly made it more difficult to access training, build and maintain a cadre of quality HCTC foster parents across all areas of the State to meet the needs of children/youth and families within their community.

Since its introduction into the Medicaid benefit package, challenges in accessing HCTC services continue to be reported. The Complaint for Injunctive and Declaratory Relief and Request for Class Action, United States District Court, Arizona District, February 3, 2015 alleged service access difficulties. Challenges cited below were also outlined in Mercer's BH network assessment in 2017–2018 for children/youth in foster care being served through the Comprehensive Medical and Dental Program (CMDP).

- Limited bed capacity, especially in rural areas.
- Lengthy waits to identify and access an HCTC foster family.
- Gaps in needed services as part of the HCTC LOC (i.e., trauma-focused therapy, services specific to individuals with intellectual disabilities).
- Limitations on being able to place siblings together.
- Lengths of stay (LOS) not aligning with individual needs.

AHCCCS requested a comprehensive analysis of Arizona's current model and to evaluate national best practices and other state models to identify opportunities for improvement and enhancement within Arizona's HCTC model and services. Although HCTC is also a service available for adults, due to the importance of HCTC services to Arizona's children/youth, AHCCCS requested that this analysis focus on children/youth (including those involved in foster care) rather than also including the service for adults at this time.

PROJECT OVERVIEW

Mercer has completed an "independent assessment" of Arizona's HCTC model aimed at children and youth, with an emphasis on children/youth involved in foster care. Mercer approached the assessment in an objective manner in order to provide the State with concrete and targeted recommendations to improve/enhance the HCTC model inclusive of the following areas:

- Minimum service expectations,
- PA and CR requirements,
- HCTC training curriculum,
- Licensure requirements,

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[2] For tribal providers operating on Indian reservations, AHCCCS allows, in lieu of state licensure, federally-recognized Indian Tribes to attest to CMS via AHCCCS that the providers meet the equivalent of state licensure requirements.

- Payment and financing,
- Outcome, process, and capacity metrics that inform effective contract revisions, and
- Policy expectations.

Mercer's assessment and comparative analysis was completed across the six major task areas[3], which are used to inform recommendations throughout this report. Mercer's approach consisted of:

- A comprehensive analysis and review of the current Arizona HCTC model through the evaluation of:
  - AHCCCS materials pertaining to the HCTC benefit and training expectations.
  - DCS licensing requirements and training protocols.
  - RBHA and HCTC provider materials pertaining to contracting and HCTC service authorization.[4]
- Consideration of findings from other relevant sources of information included:
  - Interviews with AZ-FFTA, RBHAs and CRS MCO.[5]
  - Literature review and environment scan of national best practices, standards and models of TFC available from expert sources across the country.
  - Assessment of other state models in the TFC continuum.

Specifically, findings from the research conducted as part of each of the aforementioned areas were utilized to inform discussion with HCTC informants, provide the necessary context for evaluating other models of TFC, and for comparison of Arizona's model with other service delivery models. This report provides a synthesis of findings and recommendations for Arizona's consideration. The report is structured and titled in the order of the initial AHCCCS Task Order and modified to reflect the final Scope of Work (SOW) agreed upon between AHCCCS and Mercer. Section 3 of the report provides a summary of Mercer's recommendations from the various focused task areas. Section 4 consists of the methodology and findings from which the recommendations were formulated. Section 4 is further organized in accordance to the focus areas (5.0.i through 5.0.vii) explicit in the Task Order and includes additional detail and recommendations to accompany the Section 3 summary. As a result, certain topics are covered with varying emphasis in different areas of the report (e.g., training curricula are covered in Section 5.0.i, but DCS regulatory requirements for training are covered in Section 5.0.ii). Individual sections include a summary of findings and may also include recommendations for consideration. Due to the interrelated nature of each of the focus

[3] This was modified from the original seven areas per AHCCCS prioritization. The area removed from the current scope was Section 5.0.iv, Analysis of the Current HCTC Network.

[4] The initial project scope also included a network analysis pertaining to capacity, utilization, LOS and other data. AHCCCS removed this component from the final project scope.

[5] The SOW was reduced, hence removing informant interviews with HCTC licensing agencies, HCTC Professional Foster Parents, individuals and family who have received HCTC services.

areas, Mercer recommends the report and recommendations are reviewed and considered in totality before prioritizing recommendations and next steps.

3
RECOMMENDATIONS

RECOMMENDATIONS TO IMPROVE ARIZONA'S CURRENT TFC/HCTC MODEL

Based on the analysis of Arizona's HCTC model for children/youth (including those involved with DCS) outlined in this report, Mercer has summarized the following opportunities for improvement within Arizona's program. This set of recommendations offers a blueprint for Arizona to engage in additional analysis as well as take discrete steps to enhance its HCTC model and ensure continued access to this important treatment intervention within the BH service continuum.

In addition to the summary of recommendations outlined below, associated detail is interspersed throughout relevant focus areas in Section 4, Methodology and Findings, of this report. Recommendation's related to areas such as licensure requirements, minimum service expectations, and outcomes and metrics are not mentioned below but can be found throughout Section 4 of this report. Due to the utilization and responsibility for children in both the AHCCCS and DCS systems, Mercer recommends for best results, that AHCCCS and DCS collaborate in the prioritization of recommendations summarized here and throughout the report such that immediate opportunities to improve access to treatment are emphasized while efforts are made to standardize treatment delivery to all qualifying children/youth.

TFC/HCTC Policy and Treatment Model Expectations

1. Different terminology is used within DCS (e.g., TFC) and AHCCCS (e.g., HCTC) to describe this LOC and treatment services. To align with federal and local licensing terminology, Mercer recommends AHCCCS consider updating terminology to utilize TFC throughout policy and contractual documents.
2. Recommend AHCCCS establish a standardized State-level policy on HCTC; as part of this policy development, AHCCCS and DCS should:
    A. Evaluate and determine if one specific TFC model should be utilized (see Section 5.0.vi for a summary of EBPs) or if the model should vary based on region or population served. The model(s) developed/endorsed should be consistent with Arizona's 12 principles and include Meet Me Where I Am (MMWIA) practices, be evidence-based and trauma-informed.
    B. Evaluate HCTC as a service and LOC within Arizona's Children's System of Care (CSOC) continuum of services.
    C. Evaluate the feasibility of adding LOCs or tiers based on factors such as acuity, age, and/or special population. This evaluation should also include a clinical review of children/youth that are difficult to transition once discharged from the HCTC LOC.

Mercer did not review DCS policies as part of this analysis. Further evaluation of those policies as tied to this item is recommended.

HCTC Quality Monitoring and Network Management

1. Recommend AHCCCS require the contracted BH MCOs conduct a quality review of HCTC treatment services at a regularly established interval. As part of this quality review, the BH MCOs should evaluate the quality of treatment intervention as related to successful permanent placement (contingent upon availability and participation of the permanent placement parents) and other desired outcomes tied to need. Data obtained from these quality reviews may be utilized to inform AHCCCS contracting, policy updates or network management. AHCCCS should approve and monitor the BH MCOs HCTC quality monitoring process and utilization management (UM) metrics as part of their routine monitoring processes.
    A. The State should routinely monitor the number of licensed and certified HCTC beds, the number of contracted HCTC beds by BH MCO and contracted HCTC licensing agency as well as the occupancy of those beds.
    B. AHCCCS should consider further evaluation of network adequacy based on the previously referenced report and obtained data in Section 5.0.iv of this report.

TFC Training Curriculum

1. Recommend AHCCCS and DCS work with the BH MCOs, HCTC licensing agencies, HCTC foster parents and other key stakeholders to review and update the HCTC training curriculum; these updates should:
    A. Build off of the content of the Foster Parent College similarly to how this was originally done with Parenting for Safety and Permanency Model Approach to Partnerships in Parenting (PS-MAPP). However please note, Mercer was unable to analyze the quality and sufficiency of the Foster Parent College, therefore the need for this should be determined by the State.
    B. Be consistent with the Arizona's 12 principles and MMWIA practices. The curriculum should also establish core competencies including, but not limited (see Section 5.0.i for more detail recommendations) to:
        i. Understanding how trauma can impact and present in children/youth.
        ii. Cultural considerations.
        iii. Family inclusion in treatment and permanency planning.
        iv. Co-occurring physical and/or developmental conditions.
    C. Clearly delineate the qualifications, roles and responsibilities of the HCTC foster parent, HCTC licensing agency, the CFT, and the biological/adoptive parent/family identified for permanency.
    D. Clearly define the purposes of different planning processes and documents (i.e., the permanency plan, BH transition plan and BH service plan), and streamline when appropriate.

E. Determine State agency ownership and oversight of the HCTC curriculum development, ongoing updates and administration. Mercer notes that clinical expertise and background is an essential consideration in making this decision and completing the listed tasks.

2. Recommend AHCCCS and DCS determine ongoing training needs and development requirements with the contracted BH MCOs and HCTC licensing agencies. This should include the identification of processes for approval and oversight of any training determined for delivery by the HCTC licensing agency to HCTC foster parents.
3. Recommend DCS strengthen training requirements to be more defined, tied to licensure renewal, and develop a process to ensure adherence as part of license renewal.

Prior Authorization and Concurrent Review Requirements

1. Recommend UM continue to be used with HCTC services. HCTC has an important role in the Medicaid CSOC, coupled with the unique and complex nature of the clinical services provided in this LOC (LOC creates the need for active and ongoing engagement by the medical management team), to monitor and manage the quality and capacity of HCTC services. UM will help prevent abuse, uphold quality of care issues and help this emerging practice mature.
2. Currently, the variable LOC guidelines used by the BH MCOs result in inconsistent medical necessity decisions. In order to standardize practices throughout the State, Mercer recommends AHCCCS institute one standard HCTC authorization criteria that incorporates industry standards. AHCCCS may choose to utilize an established LOC guideline (e.g., Children's LOC Utilization System [CALOCUS]/Child and Adolescent Service Intensity Instrument [CASII], InterQual), that has already been designed and tested for reliability and validity. If the CALOCUS/CASII scores are used, criteria for admission, concurrent and discharge will need to be developed and assessed for reliability and validity.
3. To enhance the effectiveness of HCTC and improve outcomes, Mercer recommends AHCCCS include an HCTC admission criterion that a permanent parent, foster parent or other caregiver be identified and agree to participate in shared parenting (or that this person will be identified and/or agrees to participate within a certain period of time) as part of the Admissions/Initial criteria. This requirement could be bolstered by obtaining signed "Consent for Treatment" forms from all participants.

Payment and Financing

1. Recommend AHCCCS evaluate the following to determine if any updates in payment methodology specific to HCTC are necessary:
   A. AHCCCS fee-for-service (FFS) compared to average BH MCO rates.
   B. HCTC licensing agency compared to HCTC family reimbursement.
   C. DCS reimbursement for children/youth transitioning from higher LOC to traditional foster care.
2. AHCCCS should evaluate its rate development process to determine whether it would be more cost-effective to establish a tiered, rather than flat, rate structure and explore other state's TFC payment methodologies (see detail in Appendix B). Examples include rate banding by level of

acuity and need of child/youth being served as well as level of HCTC foster home training and experience.

3. Implement Value-Based Payment approaches and develop potential options or metrics that BH MCOs can use to incentivize HCTC parent participation and retention.

4
METHODOLOGY AND FINDINGS

5.0.I — ANALYSIS OF AHCCCS MATERIALS RELATED TO HCTC

Overview

Mercer performed an analysis of AHCCCS materials related to HCTC services with a focus on reviewing current program expectations. The results of this analysis will inform recommendations to enhance or update standards, manuals, tools and training to achieve consistency in the administration and oversight of HCTC services, provider expectations, and access to care across all geographic service areas and BH MCOs. Of particular interest to AHCCCS, results from the review of the following materials have been compared nationally to other state models and against the national literature and standards (see Sections 5.0.vi and 5.0.vii). Mercer's review focused on the following items:

- Covered BH Service Guide,
- Comparison of HCTC service elements to Behavioral Health Residential Setting (BHRF) service elements,
- BH System Practice Tools: CFT and Children's Out-of-Home Services (Including the Children's Out-of-Home Services HCTC guidelines attachment),
- RBHA contract requirements,
- Training Requirements for HCTC licensing agencies and HCTC foster parents as outlined in the AHCCCS Medical Policy Manual (AMPM) 1060, Section D and A.A.C., Title 21, Chapter 6, DCS — Foster Home Licensing,
- Arizona's 18-Hour HCTC Training Curriculum which included an overview paper, session PowerPoints, associated handouts and trainers guides as provided by DCS, and
- Arizona's Standard Foster Parent College via DCS staff interview, overview document and training catalogue.

Synthesis of Findings

Covered Behavioral Health Services Guide

The Covered BH Services Guide outlines HCTC as a service provided in a BH therapeutic home to a person residing in their home (required to be a licensed foster home certified in HCTC) in order to implement the in-home portion of the child/youth's BH service plan.[6] HCTC services are designed to

[6] AHCCCS. (2017). AHCCCS Covered Behavioral Health Services Guide. Available at: https://www.azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/covered-bhs-guide.pdf.

assist and support a child/youth and family in achieving their service plan goals and objectives. The goal is to help the child/youth divert from residential or inpatient LOCs, remain connected to the community and work towards permanency with their family, thereby avoiding residential, inpatient or institutional care. As outlined in the HCTC rate, services include supervision and the direct provision of BH support services such as personal care (prescribed behavioral interventions), psychosocial rehabilitation, skills training and development, transportation of the child/youth to therapy or visitations and/or the participation in treatment and discharge planning.[7] In addition to direct services to the identified child/youth, the HCTC services rate also includes home care training family services/support to family member(s) directed toward restoration, enhancement, or maintenance of the family functioning to increase the family's ability to effectively interact and care for the child/youth in the home and community. Room and board costs are billed outside of the HCTC rate using a modifier code (H0046 SE) for non-CMDP eligible placed children/youth. DCS-placed children/youth must first exhaust other funding sources such as dollars from DCS (AHCCCS Guide refers to the Arizona Department of Economic Security [ADES]) or Supplemental Security Income before billing AHCCCS for State-funded room and board. For all placements by DCS, room and board is paid by DCS at a rate of $20 per day. Funding of room and board costs has been assessed as part of the national research by state (See Appendices A and B, and Section 5.0.vii).

Other activities under the HCTC rate include employee supervision and training provided by the HCTC licensing agency. This includes pre-training activities associated with the HCTC foster home and required for becoming a certified HCTC foster parent. The itemized costs of such activities were not reviewed as part of this analysis. Therefore, as outlined later in this report, Arizona financial and rate data has been pulled using claims and assessed against other states' publically reported rates. A more in-depth assessment of rates at the State, RBHA/CRS MCO, HCTC licensing agency and HCTC foster family level is recommended. Mercer has flagged the inclusion of training and supervision activities in the rate as it is unclear what factors/assumptions were considered in building the HCTC rate and whether or not the rate adequately compensates for requisite training and supervision. It is also unclear if this is handled consistently across each RBHA, CRS MCO or licensing agency. Therefore, Mercer recommends a deeper analysis of the rate including payment allocations between the HCTC licensing agencies and HCTC foster family be collected and evaluated. Part of this analysis may include a surveying the HCTC licensing agencies and HCTC foster parents on payments received and paid. Potential system inconsistencies and barriers regarding compensation are outlined further within the operational feedback captured in the informant interview within Section 5.0.v.

Mercer also recommends further examination of factors which may contribute to the rate development process such as foster parent expertise, competency or level of acuity of the child/youth. Examples to consider include establishing criteria tied to level of acuity and need with reimbursement based on factors such as number of years of experience (currently one year as a

[7] AHCCCS. (2017). AHCCCS Covered Behavioral Health Services Guide, Section II.D.5. Available at: https://www.azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/covered-bhs-guide.pdf.

foster parent is required), type of children/youth served (e.g., age of the child/youth, populations requiring more specialization such as those individuals with intellectual and developmental disabilities [IDD] or transition age youth), duration of care, rate of successful outcomes, and/or training with pre- and post-test results including an inter-rater reliability (IRR) target (such as 90%) to ensure consistency in the application of the model. A comparison of Arizona's HCTC service array and rate setting process are analyzed against other state models in more detail within Appendix B, State Profiles, and Section 5.0.vii of this report. This includes whether or not tiered payments are utilized and how those tiers are defined.

Comparison of HCTC and BHRF Service Elements

Mercer reviewed and analyzed the service array and elements of BHRFs within the care continuum, because both the HCTC and BHRF settings are designed to serve child/youth with comparable levels of acuity. A review of clinical records as well as associated BH MCO medical necessity decisions is recommended to develop clinical profiles of the children/youth entering both LOCs in order to help determine the similarities and differences compared to need. The results can then be used for informing and/or enhancing the services elements and criteria for both HCTC and BHRF. BHRF services offered include various therapies, activities and experiences within the residence as well as counseling and availability of an onsite and on-call BH professional. BHRFs are available in both secure and non-secure centers as well as with and without room and board costs included.[8] BHRF are paid via daily per diem rate and is inclusive of all services (treatment and otherwise such as laundry, meals, medical, etc.).

Similar to HCTC, BHRF is designed to provide a 24-hour structured treatment setting with a comprehensive array of integrated services to meet the need of the child/youth. Both services require PA (see Section 5.0.iii for more detail on how this applied by RBHA and CRS MCO) targeted for children/youth with more complex needs. In contrast, a key difference is BHRF does not allow access to and billing for other treatment interventions outside of the residence. Although there are some limitations as noted above, HCTC does allow for other community-based services to be accessed and billed for, while BHRF, in accordance with how AHCCCS has developed the reimbursement methodology for BHRF to account for the services expected to be delivered within the setting, does not allow for outside services to be implemented or billed on the same day. This component of the task order analysis focuses strictly on these two LOCs (HCTC and BHRF). Mercer recommends that the State evaluate the full continuum of placement options within the BH service array including child welfare placement options (e.g., group home, shelter) for children/youth involved in foster care. Please note creating a distinction between settings that offer BH treatment services versus settings that offer a place to live is important in this type of comparative analysis.

[8] AHCCCS. (2017). AHCCCS Covered Behavioral Health Services Guide, Section II.G. Available at: https://www.azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/covered-bhs-guide.pdf.

In comparing the daily rates, HCTC has an average rate of $143.28 per the AHCCCS fee schedule while BH short-term residential has a rate of $201.90 (H0018). In Section 5.0.vii of this report, the analysis by year and CMDP versus non-CMDP demonstrate that HCTC has consistently been paid above the AHCCCS rate (ranging from 110% to 136%). Based on the intended level of acuity of HCTC and the idea that this LOC is designed to divert from residential, AHCCCS may consider revisiting the assumptions and factors behind the rate or consider a more in-depth rate study.

Some perceived clinical benefits inherent to HCTC include the provision of a home/family-like environment versus large campus or milieu setting; direct access to local public education in the community versus restriction to an onsite classroom; and access to community-based social activities such as sports or recreation in the community which provides a more normalized experience for the child/youth versus as a campus or milieu outing. However, in order to quantify these perceptions, a clinical record review of child/youth treatment plans is recommended.

BH System Practice Tools

Mercer reviewed AHCCCS BH system Practice Tools, including the Children's Out-Of-Home Services and CFT Practice Tools in order to evaluate current written guidance that support the provision of out-of-home services, specifically HCTC. The BH system Practice Tools serve as recommended guidelines for BH providers to provide consistent, high quality services while also providing a guide for BH MCOs to monitor fidelity of practice.

The CFT Practice Tool and AHCCCS Contractor Operations Manual 417 provides guidance regarding effective provision of covered BH services within an appropriate timeframe. The Practice Tool more specifically mentions HCTC as it relates to the development, oversight and facilitation of the Service Plan. HCTC is noted as a service requiring PA. As such, CFT facilitators are responsible with coordinating the process of obtaining that authorization which then drives the inclusion into the Service Plan. While AMPM Policy 1110 is listed in the Practice Tool as the policy reference for PA, that policy addresses PA, CR and retrospective review (RR) solely for the Federal Emergency Service Program. AMPM 820 more globally addresses PA for various service categories including BH and AMPM 1020, Medical Management Scope and Components more thoroughly addresses PA, CR and RR. Mercer is aware that all policies are in the process of being updated, consolidated and/or drafted in preparation for the launch of the AHCCCS Complete Care Contract effective October 1, 2018. Mercer recommends policies and relevant Practice Tools are reviewed by AHCCCS to ensure the references have been updated. As policies, guidance documents and other contract language are updated, Mercer recommends that sub-populations which have additional needs or require further coordination, be specifically addressed in their own sections within the documents. Examples include children/youth involved in foster care and children/youth with IDD.

CFT service plans are also designed to address transitions between various levels of service intensity. This is an important aspect of planning for permanency. Inclusion of the youth and their families or caregivers in this process is an expectation as outlined in the CFT, Transition to Adulthood and Unique Behavioral Health Service Needs of Children Involved with the DCS Practice Tools. The CFT Practice Tool provides additional guidance on the need to manage the amount of contact a child/youth has with his or her therapist, case manager or direct service provider as a

function of the child/youth and/or family making progress towards their treatment goals. It is important for the team to recognize the potential for regression during these periods and plan accordingly. Given that HCTC is a higher, more acute LOC, transition should be addressed as part of admission with discharge into the child's/youth's permanent family setting as part of the goal. Although permanency is addressed as part of DCS' child/youth case plan, the inclusion of permanency as part of the service plan is not explicitly addressed. Specific to HCTC, delayed or inadequate planning around the transition out of the HCTC foster home can lead to unnecessary longer LOS.[9] The practice protocols mention the importance of permanency for children/youth involved with DCS however they do not provide guidance or direction for CFTs on how to incorporate permanency into the planning process prior to admission, during or after discharge within higher LOCs. Mercer recommends a permanency plan be considered as a prerequisite to authorization of an HCTC admission to ensure that HCTC is utilized as a treatment intervention as opposed to a placement for the child/youth. In addition, Mercer recommends a clinical record review of children/youth placed in a HCTC episode of care in order to further assess treatment planning and transition to permanency to inform content areas in State and Contractor-level policy as well as clinical guidance and training for HCTC licensing agencies and HCTC foster parents. Since the average LOS is less than one year (see Section 5.0.iv), pulling from episodes in the last year would be sufficient. However, if the State is interested in focusing on outliers, a longer timeframe would be necessary.

It is the expectation that the BH MCOs and HCTC licensing agencies administer, guide and monitor the network of available HCTC foster homes for geographic sufficiency as well as ensuring adherence to the Arizona principles and vision. BH MCOs are expected to adhere to Federal 42 CFR §438.68 (Network adequacy standards) and §438.206 (Availability of services) and all associated State published standards. AHCCCS has put the network adequacy/sufficiency analysis (Task 5.0.iv of the Task Order) on hold for the scope of this analysis; however, it is recommended AHCCCS revisit this in the future as a second phase following any enhancements to the HCTC model (including policy and training). In lieu of a new analysis on network capacity, Mercer is referencing and excerpting the appropriate sections (including a high-level summary on RBHA actions) from the Mercer-completed *AHCCCS Behavioral Health Network Assessment — February 2018 (*represented in Section 5.0.iv of this report)[27]. Currently, based on the review of RBHA materials and informant interviews, the operationalization of the CSC and HCTC varies widely from region to region across the State. More detail on these variations are described within Sections 5.0.iii and 5.0.v of this report. Mercer recommends an initial focus on bringing consistency to the current system across BH MCOs and providers followed by an updated network assessment. Other areas of recommended focus include collection and monitoring of licensed HCTC foster homes, contracted HCTC foster homes, bed capacity and bed utilization.

[9] The importance of a permanency plan is further highlighted in discussions with RBHA clinical staff as detailed in Section 5.0.iii of the report.

The Out-of-Home Practice Tool further reiterates the need to operationalize the use of CFT practice in residential treatment facilities, BH group homes and HCTC provider settings to ensure that children and adolescents receive treatment interventions that are consistent with the Arizona Vision and the 12 Principles for Children's Service Delivery. This practice tool refers to AMPM Policy 430 pertaining to the Vision and 12 Principles, however AMPM 430 focuses on Early and Periodic Screening, Diagnostic and Treatment. In a separate project, Mercer has been involved in updating and drafting new policies for CSOC including Arizona's Vision and 12 Principles. Therefore, we are aware that the Out-of-Home Practice Tool will need to be updated to include the most current AMPM policy chapter references.

The tool further directs BH MCOs to establish their own process for ensuring that all residential service provider clinical staff working with children and adolescents understand the expectations outlined in the Practice Tool (including any updates or revisions). This includes requirements for BH MCOs to ensure that their subcontracted Behavioral Health Inpatient Facilities (BHIFs), BHRF and HCTC agencies are notified and that provider agency clinical staff are retrained on a set frequency, and that supervision regarding the implementation of the Out-of-Home Practice Tool is in place. Although there are requirements in place, Mercer has not found evidence of additional documentation that formalizes how BHIF, BHRF or HCTC are operationalized by the BH MCOs. More detail on the review of RBHA policies, manuals and medical necessity criteria can be found in Section 5.0.iii of this report. Feedback from the informant interview with the Arizona Foster Family-based Treatment Association (see Section 5.0.v) also reported lack of operational consistency. Currently there is not a State-level policy on HCTC. Mercer recommends that a separate policy be drafted for HCTC defining roles and responsibilities between the BH MCOs, HCTC licensing agencies and HCTC foster parents, outlining how HCTC is defined including minimum service expectations, requirements for HCTC network capacity, monitoring and management (for the HCTC licensing agencies as well as the HCTC foster parents). More detailed guidance can be captured in the Practice Tools to help BH MCOs with how to operationalize the service.

Children's Out-of-Home Services HCTC guidelines, specifically identifies HCTC services as services for children/youth who, in the absence of the services "would be at risk of transitioning into a more restrictive residential setting." It also outlines expectations for the HCTC agencies, provider families and interaction with the CFT. As a result, Mercer would expect to see more information within BH MCO policies on how this is operationalized and monitored; however, this level of detail was not found in the materials provided or researched. Mercer recommends AHCCCS update contract and policy language to provide a required set of operational expectations, such as minimum service elements, across all BH MCOs, HCTC licensing agencies and HCTC foster parents. It is also recommended that Contractor-level policies are reviewed and approved by AHCCCS to ensure consistency with State requirements. As stated earlier, per informant feedback, how the service is operationalized differs by region and RBHA. Currently, the Practice Tools are referenced as recommendations or resources. One way to impact quality and consistency of practice is to start by requiring the guidance within the Practice Tools in contract. Mercer also recommends that AHCCCS direct its BH MCOs to develop and implement a monitoring process

against the practice guidelines. For the purposes of consistency, it is further recommended that AHCCCS set minimum required metrics and activities specific to the HCTC licensing agencies as well as the HCTC foster parents. For the effectiveness of this service, metrics for consideration include things that are likely documented in the service plan such as permanency and discharge planning, incidents reported to DCS, participation in the CFT.

There are not specific requirements for HCTC licensing agencies regarding supervision and oversight. As described in the national literature (see Section 5.0.vi), ongoing supervision and support is identified as an important element within a TFC program. Therefore, Mercer recommends further analysis of how this is currently managed across the HCTC licensing agencies and expansion of requirements be developed within the State issued regulations and/or guidance documents.

RBHA Contract Requirements

The RBHA contracts set basic high-level expectations on the appropriateness of HCTC and minimum expectations on policies, administration of HCTC and monitoring. The requirements are summarized below (RBHA contract sections are noted in parenthesis):

- The BH MCO shall utilize HCTC as an alternative to more restrictive LOCs when clinically indicated (4.8.4). The contract also requires admission and continued stay authorizations for children/youth in acute care facilities, BHIFs, BHRFs and HCTC facilities to be conducted by a physician or other qualified health care professional (8.6.5). Per RBHA report, the UM staff are made up of both licensed and unlicensed clinicians. When an unlicensed clinician, qualified health care professional, is making an authorization decision, they are supervised by a licensed practitioner. Analysis of medical necessity criteria as well as comparison to other states can be found under Sections 5.0.iii and 5.0.vii of this report.
- BH MCOs are expected to establish and maintain minimum network capacity standards for HCTC foster homes as directed by AHCCCS (4.8.8). Based on RBHA informant interviews (see Section 5.0.iii), it is unclear if this is happening or how this is being managed. Per the 2018 Behavioral Health Network Assessment, this was an area identified as needing attention. Analysis of the current network against these standards has been put on hold for this Task Order therefore additional research and detail will not be found in this report. However, the previous February 2018 Behavioral Health Network Assessment conducted by Mercer indicated that specialty service areas, including HCTC were insufficient in rural areas Statewide and in urban areas in the northern region.
- BH MCOs must have policies and procedures in place that govern the process for proactive discharge planning when children/youth have been admitted into acute care facilities, BHIFs, BHRFs and HCTC facilities. The intent of the discharge planning policy and procedure is to identify the most appropriate LOC and ensure linkages with medically necessary services and community supports, increase the UM oversight prior to discharge hence decreasing the rate of readmissions within 30 days of discharge (8.6.2). Based on the review, Mercer observed that the discharge criteria are either absent or lacking across the RBHAs and that permanency as

part of planning, admission and discharge is not adequately addressed throughout the State regulations, contracts, manuals and Practice Tools.

- The Contract describes how mandated trainings required for licensure, certifications and compliance (e.g., HCTCs and Community Service Agencies) are documented (18.8.5). The oversight and management of HCTC training is not mentioned as a requirement for the BH MCOs. Per inquiry with AZ-FFTA and the DCS training representative, Mercer could not adequately assess that availability of State certified trainers. Based on the information provided and researched, Mercer is unable to identify with confidence how and to what extent the training is administered in a consistent and efficacious manner. There is no written plan for quality oversight of the HCTC training itself between the State, RBHAs and HCTC licensing agencies, and therefore the potential variability in the training curriculum and skill level of the HCTC providers is unknown. More detail on training is covered later in this section.
- For subcontractors licensed as an inpatient facility, BHRF or HCTC facility, it is required that those agencies comply with BH MCO's Quality Management (QM) and Medical Management programs (20.5.24).

Recommendations for the State are to strengthen the contractual requirements with more detailed operational expectations which should be directed across all AHCCCS contracted BH MCOs, HCTC licensing agencies and HCTC foster parents to bring forth clarity and consistency, or consider a single Statewide Contractor for HCTC (as is done with some highly specialized medical services) and allow the MCOs to purchase from the single Contractor as needed. In either scenario there are pros and cons. In the first consideration, the State still needs to determine processes and procedures to provide oversight and management across multiple Contractors to ensure consistency of delivery. While with a single Contractor, the State would have to plan to ensure access to care (mitigate bottleneck of foster homes) is maintained, all geographic needs of the State are adequately addressed and help to ensure that each MCO does not impose different requirements and processes with the Statewide Contractor to manage, hence creating system burden.

Training Requirements for HCTC Providers

Mercer reviewed HCTC training requirements as outlined in regulation (see Section 5.0.ii), State documents such as manuals, policies and contracts (described earlier in this section) and the HCTC training overview, PowerPoints and associated handouts. The purpose was to determine what training requirements for HCTC foster parents are present, to ensure competency development for HCTC foster families, ensure consistent service delivery and compare to other systems for addressing gaps and identification of recommendations. This information has been synthesized below and utilized in the national comparison for the development of recommendations (further detail in Section 5.0.vii).[10]

[10] Section 5.0.ii of this report describes in more detail, the specific DCS statutory and regulatory requirements for training. Because this report follows the order/scope of the Task Order issued by AHCCCS, certain training requirements that exist

AMPM 1060, Section D, Training Requirements for RBHAs and Behavioral Health Providers, states that Medicaid reimbursable HCTC services are provided in "professional foster homes" licensed by the ADES/Office of Licensing, Certification and Regulation (OLCR) which must comply with training requirements as listed in A.A.C. R6-5-5850. As mentioned earlier, A.A.C. R6-5-5850 expired effective June 30, 2016 and was replaced by A.A.C., Title 21, Chapter 6, Department of Child Safety — Foster Home Licensing. Therefore, AMPM 1060 needs to be updated to accurately reflect current licensing references and training requirements. HCTC is not specifically named in the code but instead is referred to as TFC. To ensure consistency in terminology and naming conventions, AHCCCS may want to consider updating its language to match the code. The code further stipulates that all agencies that recruit and license professional foster homes must provide and credibly document the following training to each contracted provider:

- CPR and First Aid Training.
- Eighteen hours of pre-service training utilizing the HCTC to Client Service Curriculum.

The code however does not elaborate on what constitutes credible documentation. Therefore, Mercer recommends AHCCCS define credible documentation and/or provide guidance through policy to ensure this is done consistently across HCTC licensing agencies and allows for easier oversight of this expectation.

The foster family (requirement for all providers of HCTC services) delivering HCTC services must complete the above training prior to delivering services. In addition, the foster family delivering HCTC services for children/youth must complete and credibly document annual training requirements as outlined in A.A.C., Title 21, Chapter 6. This includes the standard foster parent training (see Section 5.0.ii of this report) as well as the specialized training requirement of an additional 24 hours for HCTC foster homes. Both the 18-hour pre-service and 24-hour annual training must, at a minimum, include the following topic areas:

- Positive behavior development and de-escalation techniques.
- The purpose and safe use of medications.
- Overview of medication interactions and potential medication reactions.

Per discussion with DCS and the informant interview with AZ-FFTA, it was learned that the standard foster parent training (previously PS-MAPP) has been replaced with a version of the Foster Parent College curriculum.

The Foster Parent College is a four-week long training consisting of both classroom and online sessions that build off one another. Key content areas are outlined in the table below. It is important to note that the topics are combined within the number of sessions indicated.

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in those regulations are described in more detail here. Please see Section 5.0.ii for a summary of the overall requirements that are referenced here.

ONLINE LEARNING TOPIC AREAS (FIVE IN-PERSON, 3-HOUR SESSIONS)	CLASSROOM LEARNING TOPICS (FOUR ONLINE SESSIONS)
1. The Child Welfare Team	1. The Preservice Training Process
2. Child Abuse and Neglect	2. Strategies to Decrease Placement Stress
3. Parent-Child Attachment	3. Cultural Issues in Parenting
4. Understanding Behavior in Foster Children	4. Working with Primary Families
5. Child Development	5. Impact of Fostering on the Caregiving Family
6. Cultural Issues in Parenting	6. Overview of Child Welfare System and Foster Care
7. Working Together with Primary Families	7. Overview of the Arizona Department of Corrections
8. Caring for Children Who Have Been Sexually Abused	8. Court System
9. Reducing Family Stress	9. CMDP
10. Foster Care to Adoption	10. BH System
11. Supporting Normalcy for Youth in Care	11. Education System
12. Trauma Informed Parenting	

PS-MAPP had a 30-hour pre-service training requirement along with three additional hours for a federally required training on Prudent Parenting. The existing 18-hour pre-service HCTC training was developed with PS-MAPP as its foundation and built upon the concepts delivered through this training curriculum. This existing HCTC training has not been reviewed or updated since the Foster Parent College was implemented in January 2018. Mercer was not able to assess the quality or content of the Foster Parent College so Mercer is unable to determine if it meets or exceeds the previous PS-MAPP content as a building block for the HCTC training. Therefore, Mercer recommends DCS undergo a process to ensure the training remains a building block for foster families who wish to specialize in HCTC and to ensure training elements such as trauma informed care, cultural relevance or family inclusion in permanency planning are not lost. Mercer further recommends that this process includes representatives from the HCTC delivery system. This includes evaluating the full array of training available through the Foster Parent College and/or developing new training.

Regarding the 24-hour annual ongoing education requirement, other than mention of this in the code, Mercer could not find any evidence of a required training curriculum, training for trainers or guidance on acceptable content areas. Mercer agrees that annual training should be a requirement, however recommend a required outline with training objectives be created in a similar fashion to the 18-hour curriculum. Although A.A.C. R21-6-331 stipulates that DCS shall approve the training curriculum and coordinate the curriculum through a licensing agency, based on interviews and DCS feedback, there is not an identified owner for the training curriculum. Therefore, Mercer recommends AHCCCS and DCS coordinate responsibility for the appropriate involvement in curriculum development and approval. Options to evaluate include assigning the training to DCS for consistency between standard foster care training requirements or assigning the training to AHCCCS to align with other specialty BH treatment models and contracting.

The training, as described, appears to be consistent with nationally recommended and endorsed training for standard foster care families. However, in order to meet the complex needs of children/youth in Arizona (i.e., higher incidents of trauma exposure, co-occurring needs such as IDD and sexualized behaviors, cross-system needs such as juvenile justice and special education), Mercer recommends enhancing the training to include, in addition to the trainings listed, an overview of trauma and the impacts of trauma, understanding BH (e.g., identifying symptoms/behaviors and needs and co-occurring conditions and needs). Due to the complexity of these topic areas, it is recommended that these sessions be delivered in the classroom setting and be developed and delivered by a clinician/foster family team to ensure both perspectives are addressed as part of the learning process. In the case of families interested in providing specialty care for complex needs children/youth, a more detailed clinically-based training should be part of the HCTC training curriculum. A summary of this training along with the identification of gaps and recommendations are described in the next section.

Arizona's HCTC Training Curriculum

The intent and goals of the 18-hour HCTC training is to provide a comprehensive and solid framework for providers of HCTC. The curriculum is broken up into six, three-hour sessions. Sessions are designed to include lecture and practice exercises to help foster families simulate the application of skills. The sessions are organized as follows:

- Becoming an Arizona Home Care Training Provider Delivering Home Care Training Services
- Strength-Based Home Care Training Service Delivery
- Using Home Care Training Services to Promote Healthy Attachments
- Shared Parenting for Home Care Training Providers
- Engaging the CFT and Managing Crises
- Preventing Disruptions and Growing Professionally

Based on a review of the full package of training materials provided by DCS, only one of the three minimally required training areas included in A.A.C. (i.e., Title 21 and Chapter 6), positive behavior development and de-escalation techniques, is addressed. Therefore, it is unclear where and by whom training on the other required elements (the purpose and safe use of medications, overview of medication interactions and potential medication reactions) is being made available, for the pre-service and annual trainings. Mercer completed a review of the available topic areas within the Foster Parent College and although Mercer identified relevant topics such as trauma-informed parenting, cultural issues in parenting, working together with primary families, working with birth parents, a series of advanced trainings on specific behaviors (anger, lying, self-injury, stealing) and behavior management, the trainings appear to be lacking around clinical diagnosis and conditions, psychopharmacology or psychiatric medication. Therefore, it is unclear which of these trainings would be accepted toward the training hour requirements. Because these training topics are more appropriately developed and delivered by a clinician or practitioner, Mercer recommends AHCCCS and DCS collaboratively explore how best to reflect these required clinical topics into the training in a manner that are clinically appropriate and reflect the needs of DCS children/youth placed into

HCTC but those non-DCS children/youth and adults who also receive those services. Without directly taking the trainings offered, Mercer is not able to provide an assessment on the quality or sufficiency of the content as it may apply to certified HCTC foster family providers. General findings to be addressed across the training materials include updating references to align with the correct licensing regulations as previously noted; industry updates such as using references to Diagnostic and Statistical Manual (DSM)-V and ICD-10-CM instead of DSM-IV, and replace and update reference from PS-MAPP to the Foster Parent College.

Additional recommendations for consideration in updating/revising the HCTC training material and teaching approach include the following:

- More clearly identify the roles and responsibilities of the HCTC foster parent provider, HCTC licensing agency, the CFT and the biological parent/family:
  - It is further recommended that this would include role playing scenarios within the CFT process.
- Define MMWIA services and how this fits with HCTC services:
  - It is further recommended that this session be developed and delivered by a State endorsed MMWIA provider.
- More clearly define the differences and purposes of the permanency plan, BH transition plan and service plan:
  - It is further recommended that this would include sample plans with “dos and don’ts” for HCTC families to look for.
- Consider developing clinical/family member trainer teams. A critical component for HCTC families is to be able to translate classroom learning into practice and understand lessons learned and practical tips.

One general observation across the documents reviewed is that they all consistently utilize old terminology (e.g., ADES instead of DCS) or have policy or regulation references that are expired or outdated (e.g., A.A.C. R6-5-5850 instead of A.A.C., Title 21, Chapter 6). As these inconsistencies have been observed, Mercer has noted as such throughout the report. However, to ensure the flow of the report is not compromised, it is Mercer’s recommendation that all materials pertaining to HCTC be reviewed for source and document reference accuracy.

5.0.II — REVIEW OF DCS LICENSURE REQUIREMENTS FOR HCTC AND DCS TRAINING PROTOCOLS FOR PROFESSIONAL FOSTER HOMES

Below is a summary of existing statutory and regulatory requirements related to DCS licensing and training of TFHs, which provide HCTC services to children/youth. This section does not describe how these regulatory requirements are operationalized by either DCS, AHCCCS, the RBHAs or providers, or provide details around the content of the training. Detail on these operational components can be found in Sections 5.0.i and 5.0.iii.

Review and Analysis of Materials and Documentation of Key Content

Title 8, Chapter 4, Article 4, Arizona Revised Statutes (A.R.S.) sets forth statutory requirements for foster homes and parents. Title 21, Chapter 6 of the A.A.C. further enumerates the foster home licensing process, including additional qualifications for specialized foster home licensing. DCS administers the process for licensing foster parents and contracts with licensing agencies to recruit and train foster parents and monitor licensed foster homes (A.A.C. R21-6-101).

DCS sets forth minimum qualifications for foster homes, and requires additional qualifications for special foster homes. In this report, Mercer has not detailed the full array of standard foster home and foster parent licensure requirements which apply to all foster homes, just those providing HCTC services. However, below is a brief summary of the licensure process, including a summary of relevant foster parent criteria, special criteria for TFHs, foster home monitoring and training requirements.

Standard Foster Home and Foster Parent Requirements

Before receiving a license, foster parents must undergo six hours of initial foster parent training,[11] receive a valid fingerprint clearance card, complete a home study and demonstrate they can provide a safe, nurturing and appropriate home for a foster child/youth. DCS issues licenses for foster homes for an initial two-year period, with the ability to renew or amend the license.

A.A.C. R21-6-301 outlines the requirements for foster parents, which, among other things, include: being 21 years of age or older; an Arizona resident and lawfully present in the United States; living in a home in which all household members pass a background check and is free of health conditions that would interfere with safe care and supervision of the child/youth; and demonstrating the stability, maturity and nurturing skills, knowledge, and ability to provide safe care to a foster child/youth. Title 21, Chapter 6, Article 3 of the A.A.C. sets forth a detailed process for how these and other requirements are assessed by the licensing agencies, including establishing requirements for foster parents such as nurturing a child/youth, providing appropriate positive discipline and not using certain types of punishment or maltreatment. It also establishes sleeping arrangement and space requirements and expectations for the provision of medical care, transportation, education, recreation and religious or cultural practices, as well as recordkeeping and participation in the child's service team. A.A.C., Title 21, Chapter 6, Article 4 outlines the licensing process, including details regarding the factors DCS will consider in making a decision regarding the license application.

Therapeutic Foster Home and Foster Parent Requirements

In addition to the standard requirements for foster parents, DCS establishes additional requirements for certification to provide specialized services, including classification as a TFH providing HCTC (A.A.C. R21-6-331). TFHs are limited to a maximum capacity of three foster children/youth (instead of the standard five) and foster parents must have experience as a foster parent or in a related

[11] A.R.S. § 8-509 requires foster parents to have at least six hours of initial training. A.A.C. R21-6-303 adds additional requirements for CPR and first-aid training. DCS reports these training requirements in total comprise 15 hours of required training, however, this total number is not explicitly stated in the statute or agency rule.

profession and receive specialized training to provide "care and services within a support system of clinical and consultative services to foster children with specialized BH needs."[12] TFH parents must have sufficient availability to meet the complexity of a child's needs, including participating in home- and community-based services (HCBS) if applicable, and providing opportunities for community-based activities. Specific training and other requirements are outlined in the Key Content section below.

Training Requirements

In addition to foster parent training mentioned above, A.A.C. R21-6-303 requires foster parent applicants to demonstrate they have completed training on exercising a reasonable and prudent parenting standard, CPR and First Aid training.[13,14] After initial licensure, the foster parent must also complete a minimum of six hours of additional training on topics relevant to the health, growth, development or welfare of a child/youth as well as maintain their CPR and First Aid training current. Failure to complete required training is grounds for an adverse licensing action against the foster parent (A.A.C. R21-6-409). To renew a license, foster parents must prove they have completed 12 hours of training during the initial two-year licensure period (A.R.S. §8-509).

Pursuant to A.A.C. R21-6-331, TFH parents must also undergo additional training (approved by DCS) that includes positive behavior development and de-escalation techniques, as well as education on medications, in the following amounts:

- Pre-certification training:
  - 18 hours of training.
- Continuing Education:
  - A minimum of 24 hours of training prior to license renewal; regulations explicitly state this coordination. In addition to being approved by DCS, will be coordinated through a licensing agency.

In addition, TFH parents must complete any other training identified in the placement agreement necessary to care for the special needs of the child/youth.

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[12] A.A.C. R21-6-309 specifies limited circumstances in which the maximum capacity requirements may be exceeded, such as maintaining children in their current placements.

[13] A.A.C. R21-6-303. The CPR and First Aid training requirements may be waived for certain health professionals or individuals with physical limitations.

[14] A.A.C. R21-6-101. Defines "reasonable and prudent parenting standard" as "the practice of making careful and sensible parental decisions that maintain the health, safety, and best interests of a foster child while at the same time encouraging the emotional and developmental growth of the child when determining whether to allow the child to participate in extracurricular, enrichment, cultural, and social activities."

DCS Monitoring[15]

DCS rule requires monitoring of licensed foster parents, who are required to ensure ongoing compliance with licensing requirements. Licensing agencies must conduct monitoring activities to assure ongoing compliance with requirements at least once every three months (A.A.C. R21-6-218). In addition, DCS conducts quarterly visits to licensing agencies. Foster parents are required to notify licensing agencies, and licensing agencies are required to notify DCS, of "unusual incidents" that may jeopardize the health, safety or well-being of a foster child/youth (e.g., serious incidents such as deaths, unexplained absences of the child/youth from the home, serious injuries, mental health crises, and other incidents, such as injuries, property damage, arrest of household members) (A.A.C. R21-6-220 and R21-6-326). In addition, licensing agencies are required to notify DCS of allegations of child abuse or neglect (A.A.C. R21-6-221).

DCS or licensing agencies may inspect or monitor homes as necessary and appropriate and may require foster parents to undertake a formal corrective action plan to remedy violations (A.A.C. R21-6-415). A.A.C. R21-6-416 specifies the criteria DCS must consider when deciding whether to issue a corrective action plan, including the nature of the violation and the foster parent's willingness to participate in corrective action. A.A.C. R21-6-414 specifies the conditions under which DCS may deny, suspend or revoke a license, or take an adverse licensing action. These include failure to comply with the licensing process, but also include refusal or failure to execute a corrective action plan to correct a violation, or living in a home with a substantiated allegation of abuse or neglect. Adverse licensing actions are subject to appeal, but corrective action plans are not (A.A.C. R21-6-417).

Key Content by Subject Matter and/or Theme

The table below documents key, summarized content of the licensure requirements that are pertinent to the provision of appropriate supports to children/youth with BH needs, including whether the requirement is applicable to all foster homes, or only specialized foster homes.

REQUIREMENT	APPLICATION	CITATION
Therapeutic Foster Home License Requirements		
Foster parent must have either one year's experience as a foster parent, three months' successful experience in child welfare, foster care, BH, education or a related profession,[16] or a college degree in health care, social work, psychology or a related BH field.	TFH	A.A.C. R21-6-331

[15] This section describes DCS monitoring of its licensed foster parents. The RBHAs conduct provider monitoring and oversight of their contracted providers as required by AHCCCS; these activities are addressed in Sections 5.0.i and 5.0.iii.

[16] Successful experience is being "responsible for the health, safety and well-being of a child or adult with BH needs for a minimum of 20 hours per week without negative actions."

REQUIREMENT	APPLICATION	CITATION
Foster parent must not have employment or commitments that interfere with the ability to meet the child's needs and provide support to the child (including participating in HCBS, as applicable).	TFH	A.A.C. R21-6-331
Foster parent must provide the child with opportunities to regularly participate in community activities.	TFH	A.A.C. R21-6-331
Foster parent must employ an approved alternative supervision plan for when the foster parent is not available, which must include appropriate care and supervision for the foster child.	TFH	A.A.C. R21-6-331
Health, Social Support and Safety		
Foster parent must provide opportunities for emotional and social development, and supports to ease distress associated with foster care and transitions.	All	A.A.C. R21-6-305
Licensure process screens for foster parent resilience and the ability to manage anger, stress and separation.	All	A.A.C. R21-6-206
Foster parent must protect and care for the health and well-being of a foster child, including providing or obtaining necessary care, obtaining well-child visits on a specified schedule, obtaining routine dental examinations and immunizations, administering medications as appropriate, ensuring safe sleeping and carrying out instructions from health care professionals.	All	A.A.C. R21-6-314
Foster parent is required to report to licensing agencies (and licensing agencies are required to report to DCS) "unusual incidents," which include but are not limited to: a mental health crisis; incidents that seriously jeopardize the health, safety or well-being of a foster child; injury, illness, change of medication or a medication error that requires a foster child to be seen by a physician, nurse practitioner or physician assistant; and the use of physical restraint to control sudden, out-of-control behavior.	All	A.A.C. R21-6-220 A.A.C. R21-6-326
Training		
Foster parent must undergo six hours of initial training, plus training in CPR and First Aid.[17]	All	A.R.S. § 8-509 A.A.C. R21-6-303
Foster parent must complete 12 hours of additional training during the first initial two-year licensure period, including six hours relevant to the health, growth, development or welfare of a child.	All	A.R.S. § 8-509 A.A.C. R21-6-303
TFH parent must complete 18 hours of pre-certification training that includes positive behavior development and de-escalation techniques, as well as education on medications.	TFH	A.A.C. R21-6-331

[17] As noted above, DCS reports that the initial training, including CPR and First Aid, totals to 15 hours, but this is not explicitly documented in the regulations.

REQUIREMENT	APPLICATION	CITATION
TFH parent must complete a minimum of 24 hours of additional training prior to license renewal, including positive behavior development and de-escalation techniques, as well as education on medications.	TFH	A.A.C. R21-6-331
TFH parent must complete any other training identified in the placement agreement necessary to care for the special needs of the child.	TFH	A.A.C. R21-6-331

Differences in Arizona's Training Requirements Compared to Other States

This section briefly summarizes differences between Arizona's foster care licensing and training requirements compared to Colorado, Indiana, Oregon, Washington and Wisconsin. While Mercer did not conduct research to understand whether training requirements in other states have an effect on TFC outcomes, Arizona may want to further explore the factors leading to the states' decisions for settling on the specified training hours (intensity/duration) and content (minimum content areas) for general foster care and therapeutic/treatment foster care.

Review of State TFC Approaches

Mercer identified 13 states with which to compare Arizona's HCTC model. States were selected based on a combination of factors, including: states currently or planning to integrate foster care populations and services into managed care, states recommended by AHCCCS and DCS, the similarity of a state's population size, and the availability of information about their TFC programs. States included in the comparison to Arizona were: Colorado, Florida, Georgia, Indiana, Massachusetts, Missouri, New York, Oregon, Tennessee, Texas, Virginia, Washington and Wisconsin. A summary of TFC models is in Appendix A. Mercer worked with AHCCCS to define the elements contained in the comparison, which include a brief description of the TFC service name, eligible clients, provider credentials and training, required service interventions, funding and payment, and notable program elements. Findings and methodology are discussed more fully under Section 5.0.vii, as well as in individual state profiles contained in Appendix B.

Mercer relied on publicly available materials to research states. Primary sources of information used included state regulations, policies and bulletins, manuals, contracts, requests for proposals (RFPs), and other state-developed information. Approved Medicaid State Plan documents, as well as pending or approved Medicaid waivers, also served as important references.

Profiles were developed for 13 states, to compare against Arizona. Mercer sought to collect information for each category below; however, states vary in the availability of content for each category. Since TFC services and components may be covered by the state children's services agency and/or paid under Medicaid, profiles contain information identifying the appropriate funder.

STATE PROFILE CATEGORIES	
Service Title/Program Name	EBPs Used
Program Overview	Required Interventions/Program Elements
Medical Necessity Criteria/Program Eligibility	Medicaid Delivery System
License/Certification	Financing Sources for TFC Services
Role of County/Child Placing Agency (CPA)	Medicaid Provider of TFC Services
Provider Qualifications and Training	Payment Methods and Rates

Summary of States' Pre-Placement, Initial and Ongoing Training Requirements
Mercer's review of other states' TFC programs (discussed more fully under Section 5.0.vii) revealed some fundamental similarities to Arizona's policies for licensure and training (i.e., states offering TFC tend to require a foster parent be licensed or certified as a traditional foster home or caregiver prior to being eligible to provide TFC services). Arizona requires foster parents have at least one year's experience (or related professional or education experience) and undergo specialized training before receiving a documented areas of certification to provide specialized services. Mercer did not discover any states that specifically license individuals as "therapeutic foster care" parents. Instead, like Arizona, states issue certifications to licensed foster parents determined eligible to provide TFC based on meeting training and other requirements.

Additionally, like Arizona, initial and pre-service training requirements for traditional foster care include a focus on common BH problems in children/youth and use of psychotropic medications, whereas TFC-specific trainings in some states place a greater emphasis on understanding trauma as well as behavior and stress management. Limitations on the number of children/youth served within a single TFC placement setting are also in use in some states (including Arizona) as well as policies regarding whether care for siblings is permissible within the same TFC setting.

However, there are also differences between Arizona compared to Colorado, Georgia, Indiana, New York, Oregon, Tennessee, Texas, Washington and Wisconsin related to the frequency, duration and scope of trainings. Currently, Arizona requires six hours of initial foster parent training (as well as CPR and First Aid), an additional six hours of post licensure training on topics relevant to the health, growth, development or welfare of a child/youth for standard foster parents, but higher training requirements for TFC parents (i.e., 12 hours during the initial licensure period, 18 hours of pre-certification training and 24 hours of additional training).[18]

[18] As noted above, these figures reflect Arizona's minimum requirements as articulated in statute and rule. Through policy and procedure, DCS has operationalized the initial foster parent training requirements to require 15 hours, although this is not explicitly documented in the regulations.

Among the states listed below, only Colorado had more intensive TFC-specific requirements than Arizona for pre-placement, initial, and ongoing training. However, Oregon's standard foster parents are required to have significantly more training hours for "basic foster care" compared with other states (i.e., 36, 24 and 18 hours for pre-placement, initial and ongoing, respectively) coupled with 28 hours of initial training for TFC parents and 16 hours of annual training for TFC parents.

The State of Colorado also extends training requirements to care coordinators within the CPA and requires care coordinators to have 40 hours of competency-based training in prescribed areas prior to taking on a TFC caseload and annually thereafter. Please see Section 5.0.vii and Appendix B for additional information, including a discussion of training topics and core competencies of TFC parents.

It is important to note that states may establish *minimum* training requirements and leave it up to CPAs to require additional training (i.e., Texas regulations mandate only two hours of pre-service training before a child/youth can be placed in the care of a foster parent). One placement agency (CK Family Services), describes requirements for "Professional Foster Parents who receive additional training and support beyond what is typical of traditional foster care." The CK Family Services website also references use of evidence-based interventions and best-practice guidelines as part of its TFC program. Please see Section 5.0.vii and Appendix B for additional information, including a discussion of training topics and core competencies of TFC parents.

STATE: TFC SERVICE TITLE	STANDARD FOSTER CARE			TFC		
	Pre-Placement	Initial	Ongoing	Pre-Placement	Initial	Ongoing
Arizona: HCTC	6 hours plus CPR and First Aid	6 hours 12 hours (initial licensure period)	6 hours	Standard foster care requirements plus 18 hours (pre-certification training)	18 hours (pre-certification training)	24 hours (additional training)
Colorado: Treatment Foster Care	Core: 27 total hours (12 hours in first 3 months. Balance in initial period.)	Core: 15 hours (reflects balance of 27 hours) Specialized: 20 hours	20 hours annually	Same as for Standard Foster Care	Competency based: 32 hours	32 hours annually
Georgia: TFC	24 hours	N/A	15 hours annually	N/A	N/A	N/A
Indiana: TFC	10 hours	N/A	15 hours annually	Same as Standard Foster Care	N/A	20 hours annually (10 general; 10

STATE: TFC SERVICE TITLE	STANDARD FOSTER CARE			TFC		
	Pre-Placement	Initial	Ongoing	Pre-Placement	Initial	Ongoing
						child-specific)
New York: Treatment Foster Care	No specified hours for pre-certification training	N/A	N/A	Same as Standard Foster Care	N/A	12–15 hours annually
Oregon: TFC	No hours specified for orientation	N/A	30 hours per 2-year certification period	N/A	28 hours	16 hours annually
Tennessee: TFC	Minimum hours referenced but, but not specified, in regulations	N/A	N/A	Same as Standard Foster Care	9 hours Juvenile Justice training 15 hours BH training	N/A
Texas: Intense Foster Family Care	2 hours	N/A	20 hours annually	N/A	N/A	N/A
Washington: TFC	24 hours	N/A	36 hours annually	N/A	N/A	N/A
Wisconsin: Treatment Foster Care	Level 2 (Basic Foster Care): 36 hours	Level 2 (Basic): 24 hours	Level 2 (Basic): 18 hours annually	Level 4 (Specialized TFC): 30 hours	Level 4 (Specialized TFC): 30 hours	Level 4 (Specialized TFC): 24 hours annually plus six hours of child-specific training.

**Note: Cells marked N/A indicates that the category is not applicable for a state.*

Summary and Analysis

It appears Arizona has relatively comparable approaches to licensing and certifying (including training requirements) providers of TFC services to those that exist in other states. One area of potential evaluation is whether respite providers for children/youth placed in TFC settings should be required to meet the same requirements as TFC homes, due to the complex needs of the children/youth served. However, Mercer recommends AHCCCS evaluate the addition of such requirements on the network adequacy and availability of respite providers, because those additional requirements may limit the number of respite providers willing and available to serve these children/youth.

In addition, as part of its future network adequacy analysis, AHCCCS and DCS should explore potential barriers to maintaining the supply of HCTC providers. Strategies to consider include increasing the number of HCTC-certified foster parents such as outreach and education to potential and current foster parents by DCS and the RBHAs.

Arizona should also evaluate the supervision requirements for licensing agencies. Supervision and oversight are important elements identified in national literature and discussed in Section 5.0.vi of the report. Arizona should analyze how licensing agencies provide supervision and develop State-level requirements for supervision.

5.0.III — COMPREHENSIVE ANALYSIS OF RBHA GUIDELINES, HCTC AUTHORIZATION CRITERIA, PROVIDER CONTRACTS, POLICIES AND TRAINING

Authorization Criteria (e.g., LOC guidelines) to determine medical necessity, practice guidelines, service descriptions and provider oversight and associated incentive programs are part of the matrix of tools BH MCOs use to shape and enhance a health delivery service system. These tools are most effective if statewide standards are in place and reflect an overall strategic plan for the development of the service delivery in a state. An important characteristic of effective standards is that they ensure similar processes between managed care entities, and simultaneously allow latitude to respond to differences in local and regional circumstances (e.g., number of providers, service delivery model, rural versus urban, etc.). This section will review the methodology used to obtain current practices, strengths, and concerns as reported by the RBHAs and CRS BH MCO, analysis of those findings, and recommendations for enhancing the capacity and quality of HCTC services.

Methodology

Mercer reviewed all publicly available documents associated with HCTC. In collaboration with AHCCCS, Mercer requested documents from the three RBHAs and CRS BH MCO specific to the managed care components evaluated in this section. An inventory of these documents can be found in Table A. After reviewing these documents, Mercer drafted interview protocols (See Appendix D) and conducted interviews with each of the RBHAs and staff engaged in the medical management and provider oversight of HCTC for children/youth. A schedule of interview participants can be found in Table B. Mercer conducted a brief, high-level search for information pertaining to federal regulations and best practices for managed care in order to inform the analysis of current RBHA authorization criteria and identified recommendations.

Table A: Inventory of HCTC-Related Documents Submitted by the RBHAs and CRS MCO

NORTH GEOGRAPHIC SERVICE AREA (GSA) RBHA	CENTRAL GSA RBHA	SOUTH GSA RBHA	STATEWIDE CRS MCO
• Agencies at a Glance Grid • AHCCCS BH Services: Foster, Kinship & Adoptive Care • AHCCCS Out-of-Home Practice Tool (Attachments A and B) • Authorization guidelines for HCTC • AZ Vision/12 Principles • BH Provider Resource List • Boilerplate Contract • Crisis Services • DCS Handout • Definitions and Acronyms • Desktop Guides CFT • Family Participation Agreement • Foster Caregiver FAPS • HCIC Committees • HCIC HH • HCTC Handbook • HCTC Map • Rate Schedule • Referral Form Schedule 1 Contract and Facility Information by Federal Tax ID	• Ancillary Services Agreement • HCTC Authorization Criteria • HCTC PA Process Flow Chart • HCTC Provider Manual Information • HCTC SOW (Attachment B) • MMIC's Navigation Forum • Therapeutic Residential Service Request	• AHCCCS HCTC Documents • BH Plan Product (Attachment A) • CIC Provider Manual • HCTC PA • Physical Health Plan Product (Attachment A)	• UHC CRS HCTC Practice Guidelines

Table B: Managed Care Entity Staff Interviewed

NORTH GSA RBHA	CENTRAL GSA RBHA	SOUTH GSA RBHA	STATEWIDE CRS MCO
• Director of Children's Services • Clinical Care Coordinator/DCS Liaison • Chief Clinical Officer	• CSOC Administrator • Quality Manager • Children's Medical Director • CSOC Manager • Medical Management • Manager of Clinical Services	• VP of Medical Management • Sr. Director of Regulatory Operations • Children's Medical Director • Manager of Children's Care Management (CM) • Manager of UM	• Director, Special Programs • BH Medical Director • CRS Medical Director • BH Network Director • Quality Review Manager — BH Provider Network and Clinical Auditing

Medical Management and Provider Oversight Findings

Authorization Criteria Introduction

LOC guidelines are a set of objective and evidence-based criteria used to make standardized and appropriate clinical placement decisions, provide the opportunity to directly address provider practice (e.g., request an enhanced discharged plan prior to providing an authorization), and detect potential quality of care concerns and referring those cases to appropriate medical review. When coupled with ongoing IRR training and testing of all staff making authorization decisions, LOC guidelines can provide a sound, evidence-based decision support structure that ensures replicable referral of an individual to the appropriate LOC and promote EBPs.

In the late 1990's, principles for LOC guidelines were developed after extensive review and research of placement practices and clinical experience of using various placement practices. Among the nine principles deemed essential to medical necessity instruments is that the instrument should be dimensional (e.g., contain a method for systematic consideration of relevant variables), quantifiable (e.g., facilitating communication, interactivity, consistency and tracking change), and reliable and valid (e.g., consistently make decisions that result in good outcomes).[19] Reliability and validity is established through a process in which mathematical validation and correlational studies results are used to revise the instrument until associated benchmarks are achieved.

Several LOC guidelines have been created and tested for reliability and validity and are licensed to managed care entities (e.g., InterQual, Milliman Care guidelines (MCG™) and American Society of Addiction Medicine criteria). Some managed care entities have developed internal, company-specific LOC guidelines, at times in collaboration with states that meet reliability and

[19] Sowers, W., Pumariega, A., Huffine, C, Fallon, T (2003). Level-of-Care Decision Making in Behavioral Health Services: the LOCUS and the CALOCUS. Psychiatric Services. Vol. 54. No. 11. Pages 1461-1463. Last accessed on August 22, 2018. https://ps.psychiatryonline.org/doi/10.1176/appi.ps.54.11.1461.

validity standards. These LOC guidelines are typically structured into three categories: Initial/Admission, CR and Discharge LOC guidelines to support reviewer decision making in each phase of treatment.

Another example of a well-established LOC guideline is the CALOCUS for Psychiatric and Addiction Services/CASII.[20] Developed by The American Association of Community Psychiatrists in collaboration with the American Academy of Child and Adolescent Psychiatry, the CALOCUS/CASII uses a dimensional rating system to determine intensity of service needs. The six dimensions are risk of harm, functional status, co-morbidity, recovery environment, resiliency and treatment history and acceptance and engagement (two scales for the child/youth and the parents/primary caretaker).

Using a multi-informant approach, the clinician rates the youth on each of the dimensions in accordance with the scale. Worksheets support consistent and accurate scoring. Scores from each of these dimensions are aggregated, and the total is used to identify one of seven LOCs. TFC/HCTC is considered Level 5, Non-Secure, 24 Hour Services with Psychiatric Monitoring. Although the CALOCUS/CASII does not provide criteria for initial, concurrent and discharge, some states incorporate the CALOUS/CASII score into LOC guidelines with the initial/concurrent/ discharge criteria structure.[21] Although CASII scores are used by the CFT to guide case conceptualization and referrals, these scores are not used as part of the current LOC guidelines for HCTC.

Current HCTC Authorization Criteria in Arizona

The North GSA and Central GSA RBHAs, and the Statewide CRS MCO use similar language in authorization criteria, with some slight variations for Initial/Admission criteria and concurrent criteria. The Statewide CRS MCO reported that they typically use MCG™ as the primary decision support instrument. However, because MCG™ has does not include criteria for HCTC LOC, this BH MCO uses the same language as the Northern and Central GSA RBHAs. Of the three, only the Statewide CRS has Discharge criteria.

The origin of the primary language used by these three managed care entities could not be definitively identified. One of the RBHAs stated that the State provided the language. Another RBHA stated that a past Medical Director had convened a group to develop the criteria. There is no indication that these HCTC LOC guidelines had undergone assessment for reliability or validity.

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[20] Fallon, Theodore & Pumariega, Andres & Sowers, Wesley & Klaehn, Robert & Huffine, Charles & Vaughan, Thomas & Winters, Nancy & Chenven, Mark & Marx, Larry & Zachik, Albert & Heffron, William & Grimes, Katherine. (2006). A Level of Care Instrument for Children's Systems of Care: Construction, Reliability and Validity. Journal of Child and Family Studies. 15. 140-152. 10.1007/s10826-005-9012-y.

[21] CALOCUS. Version 1.5 (2010). https://www.providersearch.mhnet.com/Portals/0/CALOCUS.pdf.

The fourth managed care entity, the South GSA RBHA, use the Supervised Living LOC of InterQual.[22]

Admission/Initial HCTC LOC Guidelines

Admission/Initial LOC criteria for the North, Central and Statewide CRS MCO using similar criteria have five sections: 1) Behavior and Functioning, 2) Intensity of Service, 3) Exclusionary Criteria, 4) Expected Response, and 5) Discharge Criteria Have Been Developed. Admission/Initial LOC guidelines are presented in the table below, with modifications noted with footnotes. The Statewide CRS MCO excludes all but the last paragraph in Section 2 — Intensity of Service, as noted in Table C. The South GSA is the one outlier described in Table D.

Table C. HCTC Admission Criteria used by North, Central GSA RBHAs and CRS MCO

NORTH, CENTRAL GSA RBHS AND CRS MCO
Diagnostic Criteria: Child/adolescent must have a current DSM diagnosis consistent with a DSM-V diagnosis (within the range of 290 through 316.99) which reflects the symptoms and behaviors precipitating the request for HCTC. 1. **BEHAVIOR AND FUNCTIONING (must meet)** As a result of a DSM-V diagnosis, the child/adolescent has a risk of harm to self or others or disturbance of mood, thought or behavior which renders the child/adolescent incapable of developmentally-appropriate self-care or self-regulation as evidenced by: • The child has demonstrated an inability to function in a typical family setting as evidenced by a history of risk of harm or moderate functional impairment of self-care or self-regulation due to the psychiatric condition that clearly impairs functioning, persists in the absence of stressors, and impairs recovery from the presenting problem. 2. **INTENSITY OF SERVICE (must meet all criteria)** • Homes providing HCTC services are licensed by the ADES OLCR as professional foster homes or are licensed by federally recognized Indian Tribes that attest to CMS via AHCCCS that they meet equivalent requirements. HCTC services assist and support a participant in achieving his/her service plan goals and objectives and also help the participant remain in the community setting, thereby avoiding residential, inpatient or institutional care. *Note: Criteria needs to be updated to reflect DCS.* • These services in a home setting include supervision and the provision of BH support services including personal care (especially prescribed behavioral interventions), psychosocial rehabilitation, skills training and development, transportation of the participant when necessary to activities such as therapy and visitations and/or the participation in treatment and discharge planning. • HCTC is a shared parenting concept which requires the participation of both the HCTC parents and the family of origin in order to ensure translation of skills.[23]

[22] Change Healthcare. InterQual® | Change Healthcare. Available at: https://www.changehealthcare.com/solutions/interqual.

[23] This criterion is in the North GSA RBHA LOC guidelines only.

NORTH, CENTRAL GSA RBHS AND CRS MCO

- Treatment should be at the least restrictive LOC consistent with participant need and therefore should not be instituted unless there is documentation of a failure to respond to, or professional judgment of, an inability to be safely managed in a non-therapeutic community-based placement.[24]

3. **EXCLUSION CRITERIA**

HCTC admission is not used primarily, and therefore clinically inappropriately, as:

- An alternative to preventative detention, or as a means to ensure community safety in an individual exhibiting conduct disordered behavior; or
- The equivalent of safe housing, permanency placement, or an alternative to parents'/guardians' or other agencies' capacity to provide for the child/adolescent; or
- A BH intervention when other less restrictive alternatives are available and meet the child's/adolescent's treatment needs; or
- An intervention for runaway behavior.

4. **EXPECTED RESPONSE**

Active treatment with the services available at this LOC can reasonably be expected to improve the child/adolescent's condition in order to achieve discharge from the HCTC at the earliest possible time and to facilitate his/her return to outpatient care and/or family living.

5. **DISCHARGE CRITERIA HAVE BEEN DEVELOPED**

There is a written plan for discharge with specific discharge criteria with behaviorally measurable goals, and with recommendations for aftercare treatment that includes involvement of the CFT and complies with current standards for medically necessary covered BH services, cost effectiveness, and least restrictive environment and is in conformance with federal and state clinical practice guidelines.

These guidelines include a mix of clinical symptoms and current functioning, service descriptions and practice guidelines as well as provider expectations.

The South GSA RBHA uses InterQual criteria for supervised living LOC to assist reviewers in making decisions of medical necessity. Table D lists the Admission/Initial LOC guidelines used by this RBHA.

[24] This criterion is the only one included in the Statewide CRS RBHA HCTC LOC guidelines.

Table D. HCTC Admission Criteria Used by the South GSA RBHA

SOUTH GSA RBHA ADMISSION CRITERIA
All of the following are required: 1. The child/youth presents with signs and symptoms of a psychiatric disorder which is consistent with a current DSM diagnosis (or the corresponding ICD diagnosis). A. Runaway behavior is an insufficient justification for admission to any level of out-of-home treatment as an isolated behavior. 2. The symptom or behavior which is the focus of treatment results in at least moderate functional impairment of developmentally appropriate self-care or self-regulation as evidenced by: A. Documentation of recent occurrence(s) of suicidal or homicidal ideation without plan or intent, and the inability of the child/youth and support system to carry out a safety plan; or B. Documentation of a disturbance of mood thought or behavior that clearly impairs daily functioning, persists in the absence of stressors, and impairs recovery from the presenting problem. 3. Any present medical condition can be safely managed within the HCTC setting. 4. Medically necessary outpatient BH services do not meet the treatment needs of the child/youth and there is documentation of a failure to respond or an inability to be safely managed in a less restrictive LOC. 5. The medically necessary BH treatment can be properly provided within a HCTC setting. 6. The admission is not used primarily and therefore clinically inappropriately as: A. An alternative to detention, incarceration or as a means to ensure community safety in a child/youth exhibiting primarily delinquent/antisocial behavior, or B. The equivalent of safe housing, permanent placement, or C. An alternative to parents'/guardians' or other agencies' capacity to provide for the child/youth, or D. A BH intervention when other less restrictive alternatives are available and meet the child/youth's treatment needs. 7. A preliminary discharge plan of aftercare services and supports has been developed and presented with the request for PA.

Although based on InterQual guidelines, these criteria reflect some of same requirements and in some cases similar language, as that used across the North, Central and Statewide CRS MCO (e.g., runaway behavior as the only symptom is insufficient to for any type of out-of-home placement). However, an important difference exists. In the Intensity of Service Section, Table C (North, Central, Statewide) LOC guideline states:

> *Treatment should be at the least restrictive LOC consistent with participant need and therefore should not be instituted unless there is documentation of a failure to respond to, or professional judgment of, an inability to be safely managed in a non-therapeutic community-based placement.*[25]

Whereas Table D LOC guideline (South GSA) states:

4. *Medically necessary outpatient BH services do not meet the treatment needs of the child/youth and there is documentation of a failure to respond or an inability to be safely managed in a less restrictive LOC.*

The second criterion requires a data-driven decision based on a history of failure or inadequacy of outpatient BH services. However, the first criterion requires either a data-driven decision, or professional judgement (without specifying variables used in that judgement). This difference in criteria can result in different medical necessity determinations and may contribute to the variability between managed care entities in HCTC admissions. For example, the first reviewer may make a medical necessity decision made upon clinical judgement, whereas the second reviewer may disagree with that judgement and use historical responses to interventions to make a medical necessity decision, resulting in two different decisions.

A second issue with the use of professional judgement that is not operationally defined, is that it undermines reliability between reviewers. With no standards specified in the decision making process, decisions between reviewers, and even a single reviewer across time, may not be consistent. Consequently, an initial reviewer may make an adverse determination for HCTC, whereas the appeal reviewer may authorize the HCTC request even though no additional clinical information is provided. It is however important to note that even with the development of an operational definition, normal variation in the application of criteria as evidenced by IRR testing rarely achieve 100% concordance rates among reviewers. Therefore, determining an IRR expectation with requirements should be considered in conjunction with reliable LOC guidelines.

[25] This criterion is the only one included in the Statewide CRS RBHA HCTC LOC guidelines.

Concurrent Review LOC Guidelines

Although the North and Central GSA RBHAs and Statewide CRS MCO use similar language in the CR guidelines, the Statewide CRS MCO adds the below noted exclusion criteria (however not applied to the admission criteria) as well as language addressing clinical status for discharge. For reference, the CR LOC guidelines are in Table E.

Table E. HCTC Concurrent Criteria Used by North, Central GSA RBHAs and CRS MCO[26]

NORTH, CENTRAL RBHA AND CRS MCO
1. **BEHAVIOR AND FUNCTIONING (must meet one criterion)** • Emergence or continuance of recent, recurring or intermittent episodes of risk of harm; or continued moderate functional impairment with disturbance of mood, thought or behavior which substantially impairs developmentally appropriate self-care or self-regulation; or • Significant regression of the child/adolescent's condition is anticipated without continuity at this LOC; or • The above criteria are not met, but efforts to secure a less restrictive placement suitable to the BH needs of the child/adolescent have been exhausted and none are available. Negotiation for rates for the appropriate LOC/services will be made with HCTC provider for services until appropriate placement found.[27]
2. **EXPECTED RESPONSE TO HCTC OF INTENSITY OF SERVICE** There is documented evidence that: • Active treatment, with direct supervision/oversight by professional BH staff only available at this LOC is being provided by the HCTC family on a 24-hour basis, is reducing the severity of disturbances of mood, thought or behavior which were identified as reasons for admission; and • The treatment is empowering the child/adolescent to gain skills to successfully function in his/her family and community; and • The CFT is meeting at least monthly or more frequently, as clinically indicated, to review progress, and has revised the service plan to respond to any lack of progress; and • The family or parents to whom the child/youth will be transitioned after discharge are actively involved in treatment with the child/youth and HCTC agency; and • There is an expectation that continued treatment can reasonably be expected to improve or stabilize the child/adolescent's condition so that this type of service will no longer be needed.
3. **DISCHARGE PLAN** There is a written plan for discharge with specific discharge criteria, written as behaviorally measurable goals, and with recommendations for aftercare treatment that includes involvement of the CFT. The plan complies with current standards for medically necessary covered BH services, cost effectiveness and

[26] The Statewide CRS MCO Guidelines include Exclusion Criteria from the Admission Criteria as noted in Table C.

[27] Added by Statewide CRS MCO.

NORTH, CENTRAL RBHA AND CRS MCO

least restrictive environment and is in conformance with federal and State clinical practice guidelines. This plan can be modified if the child/youth's needs change but should be started at time of admission to be clear on what goals the child/youth needs to achieve for their condition and situation.

1. Clinical Status for Discharge:
   - A. Symptom or behavior relief is sufficient. This means primary ISP goals are met or are acceptable for treatment at the next LOC (key symptom reduction). Symptom status is acceptable when symptoms are stabilized although may not be totally resolved.
   - B. Patient can participate in needed treatment in alternative setting or is HCTC setting is not meeting child/youth needs and alternative setting is needed.
   - C. No current expectation for further significant change in primary symptoms/behaviors outside of expected transition related anxiety and behaviors. Assumes a plan for transition includes intervention to decrease stresses and continue services will be in place. There is no evidence to indicate continued HCTC treatment will improve outcome over a lower LOC that is medically necessary and cost effective.
   - D. Provider and supports are sufficiently available at lower LOC. [28]

2. **EXCLUSION CRITERIA (Note: only applied by Statewide CRS MCO)**

HCTC admission is not used primarily, and therefore clinically inappropriately, as:

- An alternative to preventative detention, or as a means to ensure community safety in an individual exhibiting conduct disordered behavior; or
- The equivalent of safe housing, permanency placement, or an alternative to parents'/guardians' or other agencies' capacity to provide for the child/adolescent; or
- A BH intervention when other less restrictive alternatives are available and meet the child's/adolescent's treatment needs; or
- An intervention for runaway behavior.

The South GSA RBHA uses CR guidelines that differ significantly from the other concurrent guidelines. Table F presents the HCTC Concurrent LOC guidelines used by the South GSA RBHA.

[28] Final italicized paragraphs added by the Statewide CRS MCO only.

Table F. HCTC Concurrent Criteria Used by the South GSA RBHA

SOUTH GSA RBHA
There is documented evidence of all of the following: 1. Active treatment and supervision is being provided by the HCTC home on a 24-hour basis with direct supervision/oversight by professional BH staff; and 2. The treatment is reducing the severity of the BH issue that was identified as the reason for admission; and 3. The CFT has met every four weeks or more frequently, if clinically indicated, to review progress and revise the service plan to address any lack of progress; and 4. There is an expectation that continued treatment can reasonably be expected to improve or stabilize the child/youth's condition so that this type of service will no longer be needed.

Differences in criterion exist between the first and second set of LOC guidelines. These inconsistencies between the guidelines can potentially cause substantial differences in the ultimate decision on the medical necessity of the service. These criteria are noted in Table C (North, Central and Statewide) LOC guidelines but are absent in the Table D (South) LOC guidelines as the following requirements:

1. Significant regression of the child/adolescent's condition is anticipated without continuity at this LOC; or
2. The above criteria are not met, but efforts to secure a less restrictive placement suitable to the BH needs of the child/adolescent have been exhausted and none are available.

There are two reasons that the 1. Behavior and Functioning, second criterion (see Table E) appears criteria above may contribute to inconsistent application of medical necessity. First, the evaluation of the anticipation of the regression in condition is based on the opinion of the reviewer, without standards or operationalization. This creates a situation in which reviewer response will be highly variable and decrease consistency of decision making across reviewers and across time. Second, this criterion is not found in the South GSA RBHA LOC guidelines. Consequently, a case that is approved based on this criterion by the other BH MCOs may be denied by the South GSA RBHA.

The 1. Behavior and Functioning, third criterion (see Table E) appears to suggest that HCTC services continue to be provided even though the youth no longer meets medical necessity. Based on a high-level review of federal regulations pertaining to managed care, this criterion should be evaluated for compliance with federal regulations and State requirements for Medicaid coverage.

Discharge LOC Guidelines

Of the four managed care entities, only two have discharge criteria. Both the Central and North GSA RBHAs stated that they did not have Discharge LOC Guidelines because they were not provided in the originating document. The discharge criteria used by the South GSA RBHA and the statewide CSR MCO are not the same. The following table G compares the discharge criteria for these two organizations.

Table G. HCTC discharge Criteria Used by the South GSA RBHA and the CRS MCO

SOUTH GSA RBHA	CRS MCO
1. To be considered for discharge from the HCTC setting, the following criteria are met: A. There is a written plan with specific discharge criteria, written as behaviorally measurable goals, B. There is documentation that the CFT is involved in the writing of the discharge plan, C. The plan complies with current standards for medically necessary covered BH services, cost effectiveness, and least restrictive environment and is in conformation with federal and State clinical practice guidelines, D. The child/youth's treatment plan goals, as identified at admission to this LOC, have been accomplished, or E. The child/youth is not making progress toward treatment goals and there is no reasonable expectation of progress at this LOC.	1. Clinical Status for Discharge, ALL of the following criteria are met: A. Symptom or behavior relief is sufficient. This means primary ISP goals are met or are acceptable for treatment at the next LOC (key symptom reduction), symptom status is acceptable when symptoms are stabilized although may not be totally resolved. B. Patient can participate in needed treatment in alternative setting or the HCTC setting is not meeting child/youth needs. C. No current expectation for further significant change in primary symptoms/behaviors outside of expected transition related anxiety and behaviors. Assumes a plan for transition includes intervention to decrease stresses and continue services will be in place. D. There is no evidence to indicate continued HCTC treatment will improve outcome over a lower LOC that is medically necessary and cost effective. E. Provider and supports are sufficiently available at lower LOC. 2. Intervention: A. Patient and/or family/caregiver supports understands follow-up treatment and crisis plan. B. Coordination of care and transition planning in process. (Reconciliation of medications and follow up appointments made).

The presence of discharge criteria can strengthen the reliability and validity of the LOC guidelines tool and is a typical industry practice when the LOC structure includes three phases of treatment. In the current situation, two of the managed care entities have discharge criteria, and two do not, which contributes to the variability in reviewer determination of medical necessity across the State.

For example, in the South GSA RBHA Guidelines criterion letter E. states: *"the child/youth is not making progress toward treatment goals and there is no reasonable expectation of progress at this LOC*." A criterion of this type is typical in discharge criteria, and ensures that individuals who are no longer receiving a benefit from a service are discharged to a more appropriate and effective LOC. However, the absence of this criterion in other guidelines will contribute to inconsistent determinations of medical necessity between managed care entities, frustrations for stakeholders who expect some standard utilization practices across the State and may contribute to longer LOS in these settings.

HCTC UM Procedures, Care Coordination and Medical Management

The RBHAs and the CRS MCO must comply with contract requirements, federal and state requirements for conducting UM activities. The medical management team includes licensed physicians, psychiatrists, nurses and licensed clinicians. Denials or reduction of service must be determined by a physician or nurse practitioner. IRR testing must occur annually for all clinical staff involved in clinical review to ensure consistency of clinical determinations.

When conducting a clinical review, an important factor is the level of restriction a clinical service provides. Generally, the more acute the individual's BH symptoms, with higher levels of risk for harm, aligns with higher levels of BH treatment with corresponding higher levels of restrictiveness. Lower symptom acuity allows treatment to occur within a less restrictive environment. When LOC Guidelines include level of restrictiveness, it is referencing BH treatment restrictiveness. Restrictiveness in the public welfare system is a different concept, and is not addressed by either LOC Guidelines or used to make a determination of medical necessity, although public welfare placement and its restrictiveness may be considered as part of the youth's context.

The managed care entities have various approaches to UM, care coordination and operationalization of the CFTs who plan the youth's care. The approach used is integrated into that organization's health delivery model. Despite these different approaches, all of the organizations coordinate with the CFTs and, as appropriate, the High Cost/High Need (HCHN) program. This program identifies AHCCCS child/youth who have high behavioral and physical health needs and/or high costs. The RBHAs convene high-level meetings to coordinate care, discuss barriers and outcomes and affect change. The RBHAs are required to report a summary of HCHN outcomes twice a year.

The North GSA RBHA utilizes a Health Home (HH) health care delivery model. Although the RBHA provided the UM function (PA, CR) at one time, they asked their HHs to assume responsibility for HCTC UM as the HHs are more engaged with the CFTs, the HCTC agencies and the youth. The CFTs generate a referral to HCTC as part of the youth's ISP and give the referral to the HH. The HH clinical team assesses the referral. In this model, the clinical team refers to the HH clinicians who

have the authority to decide if the request for HCTC meets MNC. This is different from the clinician on the CFT, whose role is to develop and implement the service plan and services. If the clinical team determines that the youth does not meet medical necessity for HCTC, the HH issues a Notice of Action and supports the CFT's search for alternative services. If the HCTC LOC is approved, the clinical team searches for a HCTC licensing agency with a HCTC foster family that is a good fit for the youth. If a youth is in HCTC for more than six months, HCIC partners work with the HH and the HCTC provider to develop new treatment strategies to support the youth's recovery.

The North GSA RBHA provides its CFTs, HCTC licensing agencies and HCTC foster families with substantial information and direction in addition to the HCTC-related materials developed by AHCCCS. A desktop guide for the CFTs provides guidance on when and how to make a HCTC referral. A Northern Arizona HCTC Handbook provides information on licensing, referrals, the role of the CFT with the HCTC families, service planning, expectation of the HCTC licensing agency services and supports for the foster families as well as service expectations. Service expectations include at least one in-home visit by an in-home consultant or family therapist who receives supervision from a licensed clinician.

In addition to care coordination by the HCTC agency, the HH and HCIC, youth determined to have HCHNs are referred to the HCHN program, although most HCHN youth are reported to be in a higher LOC such as a BHRF.

The other three managed care entities manage HCTC services and providers directly. All three have established protocols and forms for the CFT to make referrals for HCTC. The Central GSA RBHA noted longer placement times due to challenges in obtaining all the needed information and the family matching process. A dedicated coordinator arranges for overnight stays and day visits with potential HCTC families to ensure that the family and the youth are a good fit prior to placement. Although this process is slower than other types of services and placements, RBHA medical management staff consider it to be necessary for good outcomes due to the personal nature of the service and for a greater degree of sustainability in the initial HCTC placement.

The RBHA health plan liaison manages and coordinates youth deemed to have HCHN, with a referral to the HCHN team. This team brings together stakeholders to develop a plan that can address the needs of the youth. If the team is experiencing challenges or encountering barriers to appropriate services, a CSOC care coordinator assists the HCHN Care Manager or the CFT, as needed.

The South GSA RBHA also receives referrals from the youth's CFT. Many times the UM CM works directly with the CFT team and assists in gathering all the needed clinical information required to make a medical necessity determination. In urgent situations, or if the UM staff do not think the case meets medical necessity after all the clinical information has been gathered, the RBHA assigns a HCTC coach. The RBHA reports that the coach's job is to assist the CFT in finding alternative services. The RBHA reports that the coach's additional assistance in finding resources is popular with both CFTs and DCS, and are specifically requested by CFT and DCS, although the number of

coaches was not noted. The RBHA also has a HCHN coordinator who coordinates care between the HCHN team and the HCTC foster family.

HCTC users from the CRS population are few in number. At the time of the interview with the CRS MCO, nine youth were in HCTC. Requests for HCTC are reviewed by the Medical Director. Even with such small numbers, an appropriate HCTC placement is not always available due to the special needs of the youth in the CRS network.

Although the RBHAs and CRS MCO have various approaches to the UM and care coordination of youth receiving HCTC services and their transition between types of services, they all have dedicated additional staffing resources to manage and support this LOC. Reasons offered for the need for additional resources includes the complexity of the youth who can benefit from HCTC, the personal nature of the service, and the multiple adults involved in the lives of some of these youths, who at times have conflicting perspectives and agendas for the youth. However, despite the need for additional resources, the medical management teams unanimously reported that HCTC services represent a valuable component in the continuum of BH services for children and youth.

Strengths and Opportunities

The RBHAs/CRS MCO medical management teams noted several strengths unique to HCTC services. Strengths include the requirement of additional training of the HCTC foster parents, and the shared parenting model in which the HCTC foster parents work with the parents/caregivers in the permanency plan. Both requirements help the foster parent providers to expand parenting skills and learn how to meet the specific needs of the youth. Clinicians on the medical management team observed that the most successful outcomes for HCTC are with those youths who have a permanency plan and parents or foster parents are involved in the HCTC shared parenting component of the HCTC service.

Noted barriers by the RBHAs/CRS MCO to good HCTC outcomes includes those cases in which the parents do not engage with the shared parenting component of HCTC. Some parents perceive the HCTC family as a threat to their own competency as parents and resist involvement. In other instances, in the rural and frontier areas of the State, distance and related transportation needs are barriers to full participation in shared parenting activities. Medical management teams reported that, at times, the child/youth is ready for discharge from HCTC services but the parents are not. The particularly problematic cases are those in which there is no permanency plan and no parents or caretakers involved in the shared parenting component of HCTC. As described by one clinician, “HCTC is an intervention into a family system, and when parts of that system are missing, the likelihood of a good outcome decreases.”

The RBHAs reported that an associated barrier is the reaction of potential foster or adoptive parents to a child/youth in HCTC. Often, children/youth within an HCTC setting are regarded as difficult to manage and are less likely to be adopted or fostered, thereby creating additional challenges to developing a permanency plan.

A related concern voiced by all medical management team members is the clinical impact of the lack of a permanency plan on youth receiving HCTC services, particularly on youth with trauma in their background and subsequent attachment difficulties. The youth may begin to heal from the effects of trauma and, in the absence of permanent parents or foster parents, attach to the HCTC parents. When the youth no longer meets medical necessity for the HCTC and is discharged to a group home or other non-permanent placement, the youth can be re-traumatized.

In other situations, when a permanent home is found for the youth and the youth is discharged to that home, the transition requires additional time for the youth to make the adjustment and attach to the new caregivers. At times, the youth and their new families are not provided with sufficient transition time or help in making that transition, as the youth no longer meets medical necessity and is discharged to the new family. If the youth has lived with the HCTC family for a long period of time with no other supports, the youth may require time to detach from the HCTC family and attach to the new family.

Medical management staff discussed various solutions they have either tried or contemplated. The most frequently mentioned possibility is for the HCTC family to become the youth's permanent foster family. However, several barriers exist to make this a scalable solution. One barrier is the general paucity of HCTC families and the reluctance to lose that family from the HCTC network.

Another barrier is associated with licensing regulations which prevent a family from holding both a foster parent license and a HCTC Certification. Consequently, the option of a HCTC family permanently fostering one youth, and accepting another for HCTC services is not available, although the family may seek an exception through DCS. This licensing regulation also presents challenges when a HCTC youth turns 18 and becomes a legal adult. AHCCCS guidance specifically states a youth turning 18 should not be reason to discontinue services. However, there are different licensing requirements for services for children/youth versus adults. Therefore, either the youth is moved from the HCTC home, or the HCTC family would be required to transition to a license allowable for adults.

One medical management team member noted that the current CSOC could be enhanced with a longer term solution for those children/youth that require long term, ongoing in-home services. One option is an enhanced level of foster care in which the youth either discharges to the enhanced foster care family, or the HCTC family becomes an enhanced foster care family thereby preserving the relationship between the youth and the HCTC family.

In addition to this constellation of issues associated with the lack of a permanency plan, other issues cited include stakeholders with differing opinions, lack of clarity between HCTC and regular foster care by stakeholders and challenges in developing a sufficient workforce of HCTC families for youth with complex medical and BH needs.

Practice Guidelines, Service Descriptions and Provider Oversight

Most of the practice guidelines and service descriptions provided by the managed care entities incorporated, by reference, AHCCCS generated documents (e.g., the Covered BH Services Guide, Children's Out-of-Home Services Practice Tool, Attachment A. Children's Out-of-Home Services HCTC guidelines). Each managed care entity provides additional information and detail. The Northern Arizona HCTC Handbook identifies the HCTC model as PS-MAPP and Deciding Together. This handbook contains detailed and additional information on the services to be provided by the HCTC foster parents as well as the responsibility of the HCTC licensing agencies. Information included provider expectations, including a minimum of monthly in-home meetings with the HCTC foster parents, the type of therapies that should occur during these meetings, and supervision requirements as well as professional development requirements and monitoring of the HCTC foster families. The RBHA requires quarterly capacity reports and meets with the agencies monthly. HCTC licensing agencies are expected to attend collaborative meetings called by the RBHA for contracted agencies. These activities constitute provider oversight.

The Central GSA RBHA has developed a SOW that is appended to HCTC licensing agency contracts. In the section labeled Specialized Program Service Requirements, UM procedures are described, HCTC licensing agency responsibilities for recruiting and training families are described, as well as specific provider expectations regarding the agency's support of the HCTC foster parents. Contact with the families are to be minimally, weekly by telephone and twice a month in-home unless higher frequency is needed. The SOW includes sections on Performance Improvement (PI) that requires the provider to participate in performance initiatives and reviews in addition to specifying documentation requirements. The RBHA did not indicate any current PI efforts at this time. In the Provider Data and Reporting section, the HCTC agency is required to provide the referring provider for each youth, a written monthly update of interventions and progress towards treatment goals, as well as monthly census reports to the RBHA, although the RBHA did not provide substantiating information or data.

The Central GSA RBHA conducts annual audits of the HCTC agencies with a record review and staff interviews to assess the agency's compliance with provider requirements in the SOW. Areas of the audit include the following:

- **Assessment and Evaluation:** Assesses whether or not the chart has a current evaluation and assessment that are youth and family oriented, recovery based and culturally competent.
- **Active Treatment:** Reviews the treatment plan to validate it is current and comprehensive, with documentation related to the youth's progress in achieving treatment goals, CFT input and HCTC goals align. This review also validates the inclusion of a crisis plan as well as all required documents, and evidence of ongoing training supervision and support for the HCTC family.
- **Family Involvement:** Reviews for active family/guardian engagement in treatment and the CFT meetings, as well as evidence of ongoing communication between the child/youth and family outside of treatment sessions.
- **Cultural Competence:** Reviews the chart to ensure services and discharge planning are responsive to child/youth and family's strengths, needs and cultural preferences.

- **Discharge Planning:** Reviews the discharge/transition plan to validate the inclusion of realistic goals, useful skills and CFT involvement.

If the RBHA discovers a problem, the HCTC agency is put on a PI plan. The RBHA did not provide the sampling rate.

The South GSA RBHA has licensing, UM requirements and clinical documentation requirements in the provider manual. Practice guidelines in supplementary documents include AHCCCS documents by reference. In compliance with AMPM 910 QM/PI Program Administrative Requirements, the RBHA conducts annual provider audits of HCTC agencies for compliance.

For all of the agencies, documentation of the agencies' supportive activities was minimal, as was knowledge of how much of the HCTC rate was kept by the agency. None of the managed care entities were able to describe the clinical model used by the HCTC agency or the HCTC families, although they all mentioned the need for trauma-informed care (TIC), and two of them provide or require additional TIC training.

HCTC Recommendations

The social and emotional situations of the youth and their families who receive HCTC services, in general, is complex. Based on the data provided by AHCCCS, half of HCTC youth are under DCS custody, and systemic factors constitute a significant dynamic in placement and outcome of clinical treatment. The uncertainty surrounding the future home of the youth creates additional challenges to successful treatment. Although no single intervention will resolve the challenges associated with these complex situations, the following recommendations are offered as changes that can increase the effectiveness and standardization of HCTC services as a clinical service within the array of Medicaid BH services offered to children and youth in Arizona.

HCTC Authorization LOC Guidelines and Medical Management

- UM (PA, CR and RR) should continue to be used with HCTC services. HCTC's important role in the Medicaid CSOC coupled with the unique and complex nature of the clinical services provided in this LOC creates the need for active and ongoing engagement by the medical management team, to monitor and manage the quality and capacity of HCTC services. UM will help prevent abuse, uphold quality of care issues and help this emerging practice mature.
- Currently, the various LOC guidelines used by the managed care entity may contribute to inconsistent medical necessity decisions both between organizations and across time within an organization. In order to standardize UM practices throughout the State, AHCCCS may want to consider mandating uniform HCTC authorization criteria guidelines that conform to current industry standards.
- AHCCCS may choose to utilize an established LOC guidelines (e.g., CALOCUS/CASII, InterQual), that has already been designed and tested for reliability and validity. AHCCCS may choose to develop its own LOC guidelines for HCTC. The benefits of developing a standard set of HCTC LOC guidelines is that it can reflect the needs and "lessons learned" from the State's experience with this service. Any or all LOC guidelines used for HCTC (including current LOC

guidelines if these are retained) should include activities that demonstrate both the reliability and the validity of the tool.[29]

  - Reliability, a component of the assessment for validity, is the tool's ability to support the same decision outcomes by multiple reviewers trained in a standardized approach to using the tool, as well as support the same decision outcome by one reviewer across time. Reliability can be assessed by using statistical techniques to determine internal consistency or test/retest scenarios with analysis for consistency as well as other approaches. The process of establishing reliability may require revisions to the tool, as sources of variability emerge.
  - Validity is the ability of the tool to accurately predict outcome (e.g., whether or not this individual will respond to HCTC with decreased symptoms and increased functioning). Validity can be assessed through content, correlation studies with other instruments and benchmarks. Validity and reliability of the HCTC LOC guidelines helps ensure that consistent decisions will be made Statewide, and that the youth and their families receive appropriate care.

- Because the CR guidelines, 1. Behavior and Functioning, third criterion (see Table E) appears to suggest that HCTC services continue to be provided even though the youth no longer meets medical necessity, this item should be evaluated for compliance with federal regulations and State requirements for Medicaid coverage if managed care entities continue to use this criterion.
- HCTC treatment includes a shared parenting component, in which the parent/caregiver learns new ways to work with the youth in the HCTC home. To enhance the effectiveness of HCTC and increase good outcomes, AHCCCS should consider including a HCTC admission criterion that a permanent parent, foster parent or other caregiver be identified and agree to participate in shared parenting (or that this person will be identified and/or agrees to participate within a certain period of time) as part of the Admissions/Initial criteria. This requirement could be bolstered by obtaining signed Consent for Treatment forms from all participants.
- Given the concerns related to re-traumatizing youth who have only attached to HCTC families, AHCCCS and DCS should dedicate resources and leverage Statewide knowledge to create innovative and intentional strategies for protecting youth at risk for experiencing additional trauma. For example, AHCCCS might convene a work group of stakeholders (including providers and medical management teams) to start with the approaches already explored by the medical management teams described earlier, and brainstorm ways to reconfigure the system to address ways to support traumatized youth.

[29] Sullivan, G. M. (2011). A Primer on the Validity of Assessment Instruments. Journal of Graduate Medical Education, 3(2), 119–120. http://doi.org/10.4300/JGME-D-11-00075.1.

HCTC Clinical Model, Service Description and Provider Oversight

- As understanding of the impact of trauma on psychological health and behavior has increased over the past 20 years, older behavioral approaches have been revised and modified for individuals with trauma, such as Trauma Informed Cognitive Behavioral Therapy. Other approaches, such as a token economy or some other point system that is based on a purely behavioral model, may be highly effective to manage disruptive behavior displayed by youth with a conduct disorder, but may re-traumatize a youth with significant trauma history. These behavioral approaches have not been revised for trauma informed care. AHCCCS may want to consider convening a Statewide group of managed care entities and providers to consider most the most appropriate clinical models for use in HCTC services for traumatized youth, and develop a plan for disseminating and implementing these models in HCTC services.
- The relationship between the HCTC agency and the HCTC family is opaque, and the level and effectiveness of support provided the HCTC families is not known. For example, none of the staff interviewed could report what percentage of the HCTC service fee is generally kept by the agency, and what percentage is given to the families. One staff person stated that she "heard" 50% of the fee was shared with the families. This lack of information is a barrier to an evaluation of which HCTC agencies and families are most effective and why, and how more qualified HCTC families can be recruited and trained and incentivized to provide value-based care. AHCCCS may want to consider adding a requirement that the RBHAs collect information and increase monitoring of this relationship, including how much support the agencies provide the families.

5.0.IV — ANALYSIS OF CURRENT HCTC NETWORK

Per AHCCCS direction, this task of the was removed from the SOW. However, some components of the data such as utilization and LOS was agreed upon between AHCCCS and Mercer. Summaries of this data are reflected in the tables below. The data pulled to populate the tables below came from claims and encounters over an evaluation period of October 1, 2012–September 30, 2017. However, as referenced in earlier sections of this report, Mercer completed a Behavioral Health Network Assessment which was published in February 2018. HCTC was specifically evaluated, along with respite, non-emergency transportation and crisis services.[30]

Specific to HCTC, the assessment included a geo-spatial analysis, utilization trending and activities being implemented by the BH MCOs. Examples of relevant activities reported and recommendations included the following:

- RBHA, CMDP and DCS care coordination activities were taking place with CIC and HCIC.
- Meetings with HCTC licensing agencies to shape service delivery were taking place with HCIC.
- It was recommended that "all BH MCOs should assess the sufficiency of the network to provide HCTC services and develop a sufficient number of HCTC foster families that are accessible to

[30] February 2108 Behavioral Health Network Assessment Report
https://www.azahcccs.gov/shared/Downloads/Reporting/201802015

CMDP including those targeting youth ages 12–17 and those with complex needs (e.g., IDD and mental health disorders).”

Average Length of Stay

Table H represents LOS for CMDP and non-CMDP child/youth as provided by AHCCCS from claims/encounter data. Spans were set up as LOS less than one year, 1–2 years, 2–3 years, 3–4 years and 4–5 years. 84.3% of the spans were under a year in length for CMDP child/youth compared to 90.8% for non-CMDP child/youth. Additionally, even though CMDP enrolled children/youth had fewer less than a year spans, their average span length by days was 36 days longer (43% longer) than the average non-CMDP enrolled children/youth. In continuation of the trend, CMDP had almost double the share of spans between one and two years (12.2%) than non-CMDP child/youth experience (6.6%) while the average length of those stays by days evened out.

Table H. LOS for CMDP and Non-CMDP Members Based on Claims/Encounter Data

		COUNTS			PERCENT OF TOTAL			DAYS PER SPAN
HCTC Span Length	Enrollment Type	Distinct Members	HCTC Spans	Days	Distinct Members	HCTC Spans	Days	Days Average
Less than 1 Year	**CMDP**	852	1,220	148,429	79.3%	84.3%	51.6%	122
	Non-CMDP	692	952	81,227	88.2%	90.8%	55.0%	85
	Summary	**1,447**	**2,172**	**229,656**	**82.2%**	**89.5%**	**52.8%**	**106**
Between 1–2 Years	**CMDP**	174	177	87,974	16.2%	12.2%	30.6%	497
	Non-CMDP	65	69	34,612	8.3%	6.6%	23.4%	502
	Summary	**237**	**177**	**122,586**	**13.5%**	**7.3%**	**28.2%**	**693**
Between 2–3 Years	**CMDP**	34	35	30,906	3.2%	2.4%	10.8%	883
	Non-CMDP	16	16	13,968	2.0%	1.5%	9.5%	873
	Summary	**50**	**51**	**44,874**	**2.8%**	**2.1%**	**10.3%**	**880**
Between 3–4 Years	**CMDP**	11	11	13,630	1.0%	0.8%	4.7%	1,239
	Non-CMDP	8	8	10,727	1.0%	0.8%	7.3%	1,341

		COUNTS			PERCENT OF TOTAL			DAYS PER SPAN
HCTC Span Length	Enrollment Type	Distinct Members	HCTC Spans	Days	Distinct Members	HCTC Spans	Days	Days Average
	Summary	**19**	**19**	**24,357**	**1.1%**	**0.8%**	**5.6%**	**1,282**
Between 4–5 Years	**CMDP**	4	4	6,508	0.4%	0.3%	2.3%	1,627
	Non-CMDP	4	4	7,095	0.5%	0.4%	4.8%	1,774
	Summary	**8**	**8**	**13,603**	**0.5%**	**0.3%**	**3.1%**	**1,700**

HCTC Utilization and LOS by Age Bands

Table I portrays the prioritized focus on the age bands for CMDP and non-CMDP children/youth in HCTC for less than one year. Age bands established were birth to two years old, 3–5 years old, 6–12 years old, 13–7 years old and 18 years and older. The 6–12 age band grouping for CMDP and non-CMDP children/youth had average span lengths under a year that were 11.4% and 19.3% longer, respectively, than the 13–17 age band. CMDP children/youth with an age of 6–12 have a 38.7% greater span average than their non-CMDP children/youth at the same age cohort. CMDP children/youth with an age of 13–17 have a 39.4% greater span average than their non-CMDP children/youth at the same age cohort.

Table I. Age Bands for CMDP and Non-CMDP Members in HCTC for Less Than One Year

HCTC SPAN	ENROLLMENT TYPE	AGE GROUP	DISTINCT MEMBER COUNT	HCTC SPAN COUNT	DAYS SUM	AVERAGE DAYS PER SPAN
Less than 1 Year	**CMDP**	**Age 3–5**	35	40	4,755	119
		Age 6–12	410	580	76,783	132
		Age 13–17	436	600	66,891	111
	Non-CMDP	**Age 0–2**	1	2	36	18
		Age 3–5	15	17	1,600	94
		Age 6–12	239	325	31,009	95
		Age 13–17	443	591	47,249	80
		Age 18+	14	17	1,333	78
		Summary	**1,447**	**2,172**	**229,656**	**106**

HCTC Utilization by MCO

Table J represents child/youth utilization counts and LOS by MCO. The CMDP MCO increases the average days per span due to their higher average than non-CMDP MCOs in general and they maintain 65% of the market for HCTC spans of less than a year by count of days. All non-CMDP contracts have an average day per span lower than CMDP MCO, except for CRS Partial Acute which is higher because of their small child/youth size. The average non-CMDP days per HCTC span is 85.32 compared to the CMDP average of 121.66. For non-CMDP children/youth, there is large variation for each of the MCOs relative to the average for non-CMDP days per span. American Indian Health Program has spans with 26% greater days than the average non-CMDP MCO. On the opposite side of the spectrum, University Family Care (South GSA) is 19% below the average for non-CMDP MCOs. Mercer decided to include the FFS data as to ensure child/youth counts were not off.

Table J. Member Utilization Counts and LOS by MCO.

HCTC SPAN	CMDP/ NON-CMDP	HEALTH PLAN	DISTINCT MEMBER COUNT	HCTC SPAN COUNT	DAYS SUM	AVERAGE DAYS PER SPAN	PERCENT ABOVE (OR BELOW AVERAGE OF TOTAL)	PERCENT ABOVE (OR BELOW AVERAGE NON-CMDP)	MARKET-SHARE W/ CMDP (USING DAYS)	MARKET-SHARE NON-CMDP
Less than 1 Year	CMDP	CMDP	852	1,220	148,429	121.66	15%	N/A	65%	N/A
	Non-CMDP	UHC	179	216	18,004	83.35	-21%	-2%	8%	22%
		AHCCCS American Indian Health Program	109	154	16,499	107.14	1%	26%	7%	20%
		Health Choice AZ	121	145	13,739	94.75	-10%	11%	6%	17%
		University Family Care	113	135	9,344	69.21	-35%	-19%	4%	12%
		LTC DD Des	58	77	5,830	75.71	-28%	-11%	3%	7%
		Mercy Care Plan	51	61	5,218	85.54	-19%	0%	2%	6%
		Phoenix Health Plan	39	46	4,597	99.93	-5%	17%	2%	6%

HCTC SPAN	CMDP/ NON-CMDP	HEALTH PLAN	DISTINCT MEMBER COUNT	HCTC SPAN COUNT	DAYS SUM	AVERAGE DAYS PER SPAN	PERCENT ABOVE (OR BELOW AVERAGE OF TOTAL)	PERCENT ABOVE (OR BELOW AVERAGE NON-CMDP)	MARKET-SHARE W/ CMDP (USING DAYS)	MARKET-SHARE NON-CMDP
		Bridgeway Health Solutions	22	28	2,639	94.25	-11%	10%	1%	3%
		CRS Fully Integrated	15	26	2,127	81.81	-23%	-4%	1%	3%
		Maricopa Health Plan	6	11	1,167	106.09	0%	24%	1%	1%
		Care1st Health Plan Arizona	24	28	966	34.5	-67%	-60%	0%	1%
		CRS Partial Acute	3	3	527	175.67	66%	106%	0%	1%
		Health Net Access[TM]	2	2	266	133	26%	56%	0%	0%
		FFS Temporary[31]	13	13	244	18.77	-82%	-78%	0%	0%
		FFS Regular[32]	7	7	60	8.57	-92%	-90%	0%	0%
Total			**1,447**	**2,172**	**229,656**	**105.73**	**0%**	**0%**	**100%**	**N/A**

[31] AHCCCS. FFS Temporary. Available at: https://azahcccs.gov/PlansProviders/FeeForServiceHealthPlans/ProgramsAndPopulations/temporary.html.

[32] AHCCCS. FFS Regular. Available at: https://azahcccs.gov/PlansProviders/FeeForServiceHealthPlans/ProgramsAndPopulations/regular.html.

Overall the data reflects longer LOS by CMDP service recipients however, based on this data alone it would not be reliable to make assumptions or hypotheses on the reason for the difference. Based on the other sections of this report, areas of further exploration may include review of permanency, geo-spatial analysis to include current network sufficiency and a clinical review of service plans to assess level of acuity as compared to LOS. Additionally, it is recommended that a review of the characteristics of children/youth who are authorized by the BH MCOs by applying the LOC guideline/authorization criterion for continued stay when there is not an alternative placement/lower LOC available. This would help to further assess the circumstances in which, specifically DCS involved children/youth, may remain in the HCTC even though medical necessity is not met and to what extent the volume of cases of children/youth are involved in DCS.

5.0.V — DISCUSSION WITH HCTC INFORMANTS

Informant Interview Background and Approach

The Task Order outlined the expectation to hold discussions with HCTC informants regarding HCTC licensing, policy, service delivery, and outcomes for children and youth receiving care in HCTC homes. Per AHCCCS, the AZ-FFTA was prioritized as a key informant. With one other exception (further discussed below), formal interviews with the following informant groups were put on hold:

- AHCCCS (questions and follow-up discussed in project meetings and scheduled as needed),
- DCS (questions and follow-up discussed in project meetings and scheduled as needed),
- HCTC provider agencies and licensed foster care families,
- Juvenile Justice System,
- Young adults who received HCTC services as a child/youth, and
- Families who have had their children/youth served through HCTC (foster/kinship/adoptive/biological).

It was determined that by meeting with AZ-FFTA, Mercer would gain valuable information about HCTC practices in Arizona, as well as information about AZ-FFTA's membership, which includes HCTC licensing agencies and HCTC licensed foster families.

In addition to meeting with AZ-FFTA, and as a result of a review of RBHA materials pertaining to Task 5.0.iii of this Task Order, AHCCCS granted approval to move forward with the RBHA informant discussions to help supplement and further inform the information shared by AZ-FFTA and to address gaps noted in the RBHA materials provided.

In preparation for each discussion, informant interview questions were drafted and approved by AHCCCS (see Appendix C and D). In total, five discussion sessions were held: AZ-FFTA, UHC, Steward Health Care Arizona, Arizona Complete Health and MMIC. Topics of discussion included the following:

- AZ-FFTA Informant Discussion Topics:
  - Best practices, uniform definition and training.
  - Medical necessity criteria, process and decision making regarding HCTC services and alignment with CFT practice.

  - Inclusion of HCTC providers in the CFT process and service planning.
  - Process for licensure and training for HCTC providers.
  - Current Arizona HCTC Practice Tool and guidance documents.
  - Recommendations on State-level policies and procedures.

- RBHA and Statewide CRS MCO Informant Discussion Topics
  - UM (including PAs and CR).
  - HCTC provider oversight — licensing agencies and HCTC foster families.
  - HCTC treatment model expectations for licensing agencies and foster parents.
  - Training.
  - Quality initiatives.

Arizona Chapter of Foster Family Treatment Association

In addition to meeting with AZ-FFTA, Mercer received a series of materials previously shared with AHCCCS that have been gathered or developed by the Association. Materials included a position paper, a proposal grid outlining current operations, needs and desired outcomes, letters to the previous Department of Health and Human Services, DCS and AHCCCS, national definition documents released by the national FFTA, RBHA HCTC medical necessity criteria, AHCCCS guidance documents and an AZ-FFTA training proposal.

As a result of the discussion with AZ-FFTA and review of the materials referenced above, several themes emerged. Please note the information provided below is organized by theme, noted barriers and recommendations by AZ-FFTA to address each barrier. The cited areas and corresponding recommendations listed below are those of AZ-FFTA and are not an all-inclusive list of barriers or recommendations. This is representative of the areas raising the most attention at the time of the discussion. It is also important to note that AZ-FFTA did not provide data to support some of the barriers and they may only be *perceived* barriers (e.g., based on mistaken perception of system rules, requirements or how the system operates); nonetheless, these perceptions may influence how AZ-FFTA child/youth interact with the system and thus become actual barriers. Thus, Mercer has conveyed these perceived barriers as they were reported because they reflect real experience in the system that may need to be addressed. Mercer's analysis has taken these barriers and recommendation into consideration and where any agreement arose is represented in the final section of this report.

HCTC is consistently reviewed and authorized outside of the CFT process. AZ-FFTA reported there is a significant gap in understanding of the foundational elements of CFT practice, particularly in the areas of training, implementation and decision-making. Subsequently, this has a direct impact on the consideration of HCTC services by CFT teams, the inclusion of HCTC providers within the CFT process and consideration of the CFT recommendations in the decision-making and approval of HCTC at the RBHA level.

1. *Barrier*: The HCTC licensing providers view the role of the HCTC foster parents and their home as the “hub” of services for the child/youth however they do not facilitate the CFT. They are merely added into the service plan as an intervention versus being engaged as a fully partner to the CFT facilitator.

   AZ-FFTA Recommendations: Update CFT guidance documents and training to address the inclusion and role of HCTC foster parents. This is recommended as a starting point for clarity on roles and responsibilities.

2. *Barrier*: Discharge planning is not addressed at the beginning of HCTC placement. This impacts the implementation of HCTC as a short-term intervention and delays transitions to a permanent family setting.

   AZ-FFTA Recommendation: Add expectations around discharge planning into CFT training, guidance documents and policy requirements and consider at admission and throughout all CFT meetings.

3. *Barrier:* DCS workers are not perceived as active members or participants in the CFT process. The experience is that once a child/youth is matched and admitted into a HCTC foster family’s home, the DCS worker disengages and HCTC home is perceived as the permanent placement.

   AZ-FFTA Recommendation: Initiate or resurrect implementation workgroup meetings to help improve the functioning of HCTC in Arizona to include DCS, AHCCCS, AZ-FFTA and other stakeholders in the community. Focus may include a training on the unique needs of children/youth in the DCS system; clearly defining the roles of the CFT, HCTC foster parents and DCS workers as active members of the CFT process.

Depending on the RBHA/CRS MCO, there are varied experiences regarding communication, publication and implementation of HCTC medical necessity criteria, including LOC, acknowledgement and consideration of the information submitted with an HCTC request from a CFT. This area of concern overlaps with the CFT concern noted above (lack of inclusion and collaboration of the CFT in the medical necessity decision-making process).

1. *Barrier:* The RBHAs/CRS MCO either do not share or make public their medical necessity criteria. The Northern region has a known PA process but does not publish their criteria. The Southern region has a very closed process and has the most number of complaints. Per the AZ-FFTA, PA in the Southern region will not be completed until there is a family match. Even at that point there is a possibility that the request will be denied. The Maricopa/Central region publishes both their PA and CR criteria online. Additionally, per an email communication between AZ-FFTA and DCS, AZ-FFTA shared a series of factors that may also prevent placement in a HCTC foster home but are not included as part of existing medical necessity criteria. The presence of these factors and their impact on provider admission acceptance decisions, demonstrate a disconnect between the existing set of medical necessity criteria and the real-life application of the admission process. The factors listed by AZ-FFTA include: Being actively suicidal, being unsafe in a community setting, the inability to be transported safely in a vehicle, active violence that has resulted in a physical restraint with the past 30 days and/or requires the HCTC foster parents to use physical interventions, extreme property damage, extreme violence

and assault that results in physical injury, being actively sexually reactive to children and pets and children with extreme needs such as toilet, bath or feed placements.

AZ-FFTA Recommendation: Require a standardized Statewide set of PA and CR criteria along with associated Statewide guidelines for authorization processes. Mercer additionally recommends the factors outlined in the above cited email be reviewed further and consider additional evaluation of this claim.

HCTC training is one of the weakest areas in the HCTC service delivery system. Training materials are outdated and inaccurate. The pool of trainers is nonexistent and there is a lack of oversight and management of training across the system.

1. *Barrier:* Current HCTC training is out date, is not inclusive of current best practices and lacks focus on the complex needs of the children/youth in the Arizona System of Care. Recently, this concern has become amplified given the change from the PS-MAPP to the Foster Care College since the existing HCTC training was built upon the context provided in PS-MAPP.

   AZ-FFTA Recommendation: Consider the purchase of existing training curriculum such as Presley Ridge, TFTC, Healing Bridges or People Places. Additionally, consider establishing a local workgroup with AZ-FFTA, AHCCCS and DCS to develop or build an enhanced version of the current training. The training updates should focus on:

   A. Roles, responsibilities and expectations.
   B. Understanding the population of children/youth being served including:
      i. Updated clinical references such as the DSM-V.
      ii. Who are successful HCTC families?
      iii. How to do the work.
2. *Barrier:* There is not a consistent process to conduct oversight of the training which impacts:
   A. Training material not being reviewed and updated regularly,
   B. Replenishing of the trainer pool to ensure Statewide resources,
   C. Consistency of training across the State, and
   D. Fidelity to the training in the field.

   AZ-FFTA Recommendation: Create a collective agreement or designate a department or team to be responsible for the areas outlined throughout the report. AZ-FFTA is willing to help facilitate and organize a plan with the State.
3. *Barrier:* The Arizona naming of HCTC and definition are not consistent with the national model.

   AZ-FFTA Recommendation: Change the name from HCTC to Therapeutic/Treatment Foster Care as outlined in the FFTA Position Paper recommendation 1.a so all documentation and

references are consistent and adopt the nationally recognized definition for Therapeutic/Treatment Foster Care.[33]

State-level licensing requirements and HCTC guidance documents are inconsistent with one another and are out-of-date.

1. *Barrier:* After a foster parent is licensed and approved by OLR, they are required to register as an NPI provider and then required to register as an AHCCCS provider. It is AZ-FFTA's understanding that Arizona is one of the only states that requires this of HCTC foster families. These requirements create an additional burden for foster families who must be responsible for meeting and maintaining records as if they were an organization.

   AZ-FFTA Recommendation: Determine if this is a requirement in order to bill Medicaid for HCTC or if another solution that would alleviate this burden for foster families (such as registering the HCTC agency versus the foster parents directly). Provide education on the requirements of the licensing agency versus the licensed foster families.

2. *Barrier:* AHCCCS issued a notice that they will no longer register a provider (licensed foster family) retroactively. For HCTC providers, this creates a challenge with the licensing renewal process. If the HCTC provider does not receive their renewal within the timeframe per no fault of their own, licensing is retroactive. However, if the AHCCCS registration is not also applied retroactively, the HCTC foster families are not able to be paid during that timeframe — causing a potential disruption in care.

   AZ-FFTA Recommendation: Consider an exception for HCTC providers or revisit the decision.

Regional Behavioral Health Authorities

Findings and feedback as a result of the RBHA and CRS informant interviews are detailed in the earlier Section 5.0.iii, of this report.

Section 3, Recommendations, of this report take into consideration the informant feedback, reported barriers, and recommendations from AZ-FFTA and the RBHAs/CRS MCO along with all other task areas and research to formulate a prioritized list of recommendations for AHCCCS' consideration.

5.0.VI — DEFINE AND EVALUATE OTHER MODELS OF TFC

Literature Review of TFC Best Practices

Mercer conducted a comprehensive literature review which included, but was not limited to, a review of peer-reviewed literature published in the United States promoting best practices in the continuum of TFC and recommendations and/or guidelines from national organizations such as the FFTA, the Child Welfare League of America (CWLA), the Substance Abuse and Mental Health Administration (SAMHSA). Additionally, online searches included key terms such as 'Therapeutic Foster Care,' 'Treatment Foster Care,' 'Evidence-Based Practices,' 'Foster Parent Training' and others. The

[33] Family Focused Treatment Association. (2016). Arizona Chapter 2016 re-submission HCTC/TFC Position Paper. Available at: https://docs.wixstatic.com/ugd/fb5186_f834a38509364cd5b339201aa736119f.pdf

information presented in the ensuing sections provides a synthesized account of the literature review findings.[34]

Recommendations and/or Guidelines from National Organizations

Lack of Standardized Treatment Foster Care Definition

The literature review demonstrates that there is no consistent and standardized definition for Therapeutic or Treatment Foster Care. In a 2012 report from SAMHSA, "What does the Research Tell us about Services for Children in Therapeutic/Treatment Foster Care with Behavioral Health Issues?"[35] the authors noted that State definitions for TFC vary, along with differing eligibility criteria and methods of implementation. Organizations such as the CWLA and the FFTA have called for a uniform federal definition of TFC. FFTA states, "A uniform, national definition clarifies an existing practice by identifying core services and adding a professional quality baseline for therapeutic foster care programs that provide intensive, individualized treatment for seriously emotionally disturbed or otherwise troubled children in a community-based setting of specialized foster homes."[36] The call for a standardized federal definition is also referenced by the Office of the Secretary for Planning and Evaluation (ASPE) in a 2018 overview of state implementation of TFC. The report states "Many stakeholders have advocated for the establishment of a federal definition of TFC…Within states, a federal definition could facilitate efforts to include TFC in amended state plans. Across states, a federal definition would also facilitate development of standard billing processes for TFC services, quality standards for program components and evaluation of TFC processes and outcomes."[37] In June 2017, there was a congressional attempt to amend the Family-Based Foster Care Services Act of 2015 to include a Medicaid definition of TFC that all states may apply. Senate Bill 429 and House Bill 835[38] sought to amend Title XIX of the Social Security Act to include a TFC definition. Language in the Bill stated "Specifically, such services are those provided for children younger than age 21 who need institution-level care but can instead be cared for in a community placement through a licensed and accredited program that: (1) provides children with certain structured daily activities, and (2) provides parents and caregivers with specialized training and consultation." The bill was supported by organizations such as the FFTA and the CWLA and while it was introduced to the Senate, the bill did not advance through the legislative process.

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[34] Casey Family Programs and Annie E Casey Foundation sources were reviewed. However, Mercer was unable to locate any relevant information pertaining to TFC.

[35] SAMHSA. (2012). What does the Research Tell us about Services for Children in Therapeutic/Treatment Foster Care with Behavioral Health Issues? Available at: https://store.samhsa.gov/shin/content/SMA14-4842/SMA14-4842.pdf.

[36] Family Focused Treatment Association. (2016). Arizona Chapter 2016 re-submission HCTC/TFC Position Paper. Available at: https://docs.wixstatic.com/ugd/fb5186_f834a38509364cd5b339201aa736119f.pdf.

[37] U.S. Department of Health and Human Services. (2018). State Practices in Treatment/Therapeutic Foster Care. Available at: https://aspe.hhs.gov/system/files/pdf/259121/TREATMENTFOSTERCARE.pdf.

[38] Congress.gov. S.1357 - Family-Based Care Services Act. Available at: https://www.congress.gov/bill/115th-congress/senate-bill/1357/actions?q=%7B%22search%22%3A%5B%22therapeutic+foster%22%5D%7D&r=1.

Use of Evidence-Based Practices

TFC is described as a clinical intervention geared specifically for children and youth with severe mental, emotional and/or BH needs,[39] and therefore, there has been a great deal of research conducted on models and suggested practices in TFC. In particular, researchers and national organizations such as SAMHSA, FFTA, CWLA and others have assessed national and state-specific trends in the use of EBPs that guide the practice of TFC.

The use of EBPs in TFC differs from state to state; however, there are several EBPs which were consistently referenced in the literature. Most EBPs are purchased directly by the provider from the owner/developer of the EBP. However, in the case of the Commonwealth of Pennsylvania, the Commonwealth does require the use of a specific EBP statewide. TFCO which was previously known as Multidimensional Treatment Foster Care (MTFC), TFTC and the TFM have all been designed specifically for TFC. Other EBPs, such as 1-2-3 Magic, Incredible Years (IY) and Parent-Child Interaction Therapy (PCIT) have all been found to have a high-level of applicability to TFC.[51] A detailed description of TFCO, TFTC and TFM can be found below. The FFTA supports the use of EBPs in TFC as indicated in the document, "Program Standards for Treatment Foster Care (2013)."[40] The FFTA developed these standards "to provide an operational definition and guide quality treatment foster care programming."[40] Specifically, the document states that "whenever possible, treatment methods should be based on research findings that support their use and efficacy."[40] Standard 75 indicates that "Programs shall follow an articulated treatment model that is comprised of components that are either evidence-based or evidence-informed. Treatment parents and staff shall receive preservice training as well as annual training in the skills and knowledge necessary to effectively implement the treatment approach."[40]

It should be noted that Mercer was unable to locate fidelity tools associated with the EBPs listed above. Additionally, research indicates that there are few TFC agencies who adhere to "evidenced-based TFC models with fidelity."[41] This concern was repeated by a number of technical experts who participated in the 2012 SAMHSA panel on "What does the Research Tell us about Services for Children in Therapeutic/Treatment Foster Care with Behavioral Health Issues?" These same technical experts noted that "there is a need to expand the use of best practices in TFC…The field needs a greater uptake of evidence-based TFC programs."[35]

In a resource guide on implementing EBPs in TFC, the FFTA noted there are number of factors that may impact the implementation of EBPs by organizations. Factors may include "leadership,

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[39] State Policy Advocacy and Reform Center. (2013). Therapeutic Foster Care: Exceptional Care for Complex, Trauma-Impacted Youth in Foster Care. [online] Available at: https://childwelfaresparc.files.wordpress.com/2013/07/therapeutic-foster-care-exceptional-care-for-complex-trauma-impacted-youth-in-foster-care.pdf.

[40] Foster Family-based Treatment Association. (2013). Program Standards for Treatment Foster Care. Available at: http://www.grandfamilies.org/Portals/0/documents/Resources/Foster%20Care%20Licensing%20Resources/2013%20Program%20Standards%20for%20Treatment%20Foster%20Care.pdf.

organizational culture, organizational climate and social influence."[41] One article noted that child welfare organizations may experience unique barriers to EBP implementation such as "lack of awareness or understanding of EBP, lack of tradition adopting EBP, few organizational role models and lack of training and supervision to support EBP implementation."[41] Results of the literature review did not indicate if there is a difference in the efficacy of TFC programs depending on who administers the program (e.g., BH versus child welfare responsibility for administration).

Based on the research conducted, the following three EBPs were the most consistently referenced in the source documents as EBPs frequently utilized in the delivery of TFC. There are other EBPs that are currently utilized in the field, however Mercer chose to focus on the ones that were most frequently noted as effective EBPs for TFC.

Treatment Foster Care Oregon

TFCO is described as "an intensive TFC alternative to institutional placement for adolescents who have problems with chronic antisocial behavior, emotional disturbance and delinquency…. Activities include skills training and therapy for youth, as well as behavioral parent training and support for foster parents and biological parents." Participating youth are closely monitored by foster parents. The length of the program varies and ranges from 5–15 months.[42] TFCO has been designed for youth age 12–17 years of age and "aims to help youth live successfully in their communities while also preparing their biological parents (or adoptive parents or other aftercare family), relatives and community-based agencies to provide effective parenting and support that will facilitate a positive reunification with the family."[43] TFCO has been shown to "prevent or reduce the number of days in institutional or residential settings, prevent the escalation of delinquency, youth violence and pregnancy, increase positive academic engagement and reduce placement disruptions."[44] TFCO has also been adapted for preschool-aged children and found to have "similarly effective results."[51] This version is titled MTFC for Preschoolers (MTFC-P). Additionally, according to the Washington State Institute for Public Policy, an entity which conducts benefit-cost summaries of EBPs, TFCO has a 70% chance of producing benefits greater than the costs associated with the program.[45] The analysis compared TFCO to "treatment as usual, which typically involved placement in a group

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[41] Foster Family-based Treatment Association. Implementing Evidence-based Practice in Treatment Foster Care. Available at: https://ncwwi.org/files/Evidence_Based_and_Trauma-Informed_Practice/Implementing_Evidence-based_Practice_in_Treatment_FC.pdf.

[42] TFC Consultants, Inc. Washington State Institute for Public Policy TFCO Benefit-Cost Summary. Available at: https://www.tfcoregon.com/PDF/Washington%20State%20Institute%20for%20Public%20Policy_Benefit-Cost%20Summary%20-%202017-intro.pdf.

[43] SAMHSA NREPP: https://nrepp.samhsa.gov/Legacy/ViewIntervention.aspx?id=48.

[44] Treatment Foster Care Oregon. Available at: https://www.tfcoregon.com/PDF/One%20page%20Treatment%20Foster%20Care%20Oregon.pdf.

[45] Washington State Institute for Public Policy. (2017). Multidimensional Treatment Foster Care. Available at: http://www.wsipp.wa.gov/BenefitCost/Program/20.

home institution."[42] TFCO is listed on SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP) and is "the most well-known and well-researched model of TFC."[40]

TFCO requires specialized training for both the TFC agency and the TFC parents. The agency undergoes 18 months of training and consultation and then a process to certify the agency to the fidelity requirements of the model. According to the Oregon Social Learning Center, "There are over 40 certified TFCO programs worldwide (including the United Kingdom, New Zealand, Denmark, Norway, the Netherlands and Sweden)."[46]

Under TFCO, TFC families must complete 30 hours of pre-service training which is followed by extensive and frequent supervision, support and feedback for a program supervisor. The program supervisor who carries a caseload of 10 or fewer families "coordinates the interventions and supervises and supports the foster parents throughout treatment through the daily telephone calls and weekly foster parent group meetings. The program supervisor also coordinates the work of family and individual therapists (for therapy conducted with the youth and his or her parents), skills trainers and a foster parent liaison/trainer."[43] Mercer could not locate information about specific continuing education requirements for foster parents under the TFCO model; however, it appears that the daily phone contact and weekly group meetings facilitated by the program supervisor serve as a form of continuing education. For example, the Commonwealth of Pennsylvania has implemented TFCO as an EBP and indicates that the program supervisor provides "ongoing support and supervision"[47] to foster parents and supports them to "use behavior management methods in the TFCO foster home. Closely supervised home visits are conducted throughout the youth's placement in TFCO."[44] The goal of the home visits is to practice new skills to prepare the youth to return home. These home visits may also be conducted with the "aftercare family" or the family the youth will return to after discharge from the TFC placement. Under the TFCO model, there is daily contact with the foster family. However, the frequency of home visits could not be found in the literature. Clinically, it does seem appropriate to conduct weekly home visits with a projected LOS of no more than nine months. "Parents are encouraged to have frequent contact with the TFCO program supervisor to get information about their child's progress in the program."[47]

Together Facing the Challenge

TFTC is an "enhanced model of TFC"[48] that targets children age 3–17 and "incorporates elements from existing evidence-based treatments to fill identified gaps in usual care practice."[49,50] This model

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[46] Oregon Social Learning Center. (2016). Three Models of Implementation for Treatment Foster Care Oregon. Available at: https://www.cibhs.org/sites/main/files/file-attachments/fri_1030_garden_buchanan_three_models_of_implementation_for_tfco_4-22-16.pdf.

[47] EPIS Center. Treatment Foster Care Oregon. Available at: http://episcenter.psu.edu/ebp/multidimensional.

[48] National Institute of Health. Enhancing and Adapting Treatment Foster Care: Lessons Learned in Trying to Change Practice. Available at: https://sites.duke.edu/tftc/files/2015/11/Murray-et-al.-2010.pdf.

[49] The California Evidence-Based Clearinghouse for Child Welfare. Together Facing the Challenge (TFTC). Available at: http://www.cebc4cw.org/program/together-facing-the-challenge/.

utilizes a training/consultation approach and provides in-service trainings for both TFC supervisors and TFC parents.[47] Training classes for TFC parents include 15–30 attendees and training typically occurs over a period of seven weeks with two-hour sessions held every other week. Staff training is recommended to be delivered over a three-day intensive seminar. The goals of TFTC are identical for TFC supervisors and TFC parents and include: The building of therapeutic relationships, performing and teaching cooperation skills, implementation of effective parenting techniques (communicate effectively, set expectations, reinforce positive behavior, avoid power struggles, etc.), preparation of youth for their future by teaching independence skills, creation of a positive home environment through family fun time, taking care of self, family meetings, etc. and improvement of outcomes for youth served in TFC settings.[47]**Error! Bookmark not defined.** The training also promotes the concepts of TIC. TFTC is not currently listed on the NREPP, but is listed on the California Evidence-Based Clearinghouse for Child Welfare. TFTC has been shown to "produce positive outcomes for youth…particularly in youth well-being and permanency outcomes."**Error! Bookmark not defined.** Similar to TFCO, Mercer was unable to locate specific information about continuing education requirements for foster parents. It does appear that foster parents are provided with "coaching, consultation and performance feedback from the TFC supervisors during in-home meetings"[51] which can also serve as a form of continuing education.

Teaching Family Model

TFM targets children age 6–17 and utilizes a unique system of "teaching parents" who "offer a family-like environment in the residence." The "teaching parents" are highly trained and supervised and help with learning living skills and positive interpersonal interaction skills. They are also involved with children's parents, teachers and other support networks to help maintain progress."[52] The Teaching-Family Association develops and oversees the implementation of TFM in agencies who wish to become a certified TFM provider.[53] TFM may be applied across home-based, group home and inpatient-psychiatric settings and "may be extremely useful for treatment foster parents who require additional training in parenting techniques."[51] In TFC home settings, the model specifically calls for support of treatment foster parents via "in-service training, support groups, respite care and 24-hour a day consultation services."[50] For TFHs, TFM is recommended as a relatively short-term intervention of 6–10 weeks. TFM's primary goals include "Improved outcomes related to mental health, reduced restrictiveness of living, reunification with family and personalized goals identified by the client and the client's family."[49] TFM has been associated with "improvements in communication

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[50] Together Facing the Challenge detailed report: http://www.cebc4cw.org/program/together-facing-the-challenge/detailed

[51] Together Facing the Challenge: Implementation of Evidence-Based Treatment Foster Care through Training, Coaching, and Consultation. Available at: https://www.cibhs.org/sites/main/files/file-attachments/thurs_400_calaveras_session_3_murray_together_facing_the_challenge.pdf.

[52] The California Evidence-Based Clearinghouse for Child Welfare. Teaching-Family Model (TFM). Available at: http://www.cebc4cw.org/program/teaching-family-model/detailed.

[53] Teaching-Family Association. Program Types Using the Teaching-Family Model. Available at: https://teaching-family.org/proram-type-using/.

and relationships between parents and youth, improved child behavior and mental health, fewer criminal offenses, improved educational outcomes, less restrictive placements and favorable discharges such as reunification with biological parents."[51] TFM is listed on the California Evidence-Based Clearinghouse for Child Welfare as a promising practice and also on SAMHSA's NREPP.

Training of Therapeutic Foster Care Agencies and Parents

The research indicates that training for TFC parents varies greatly across states and TFC agencies. TFC, as a clinical intervention, requires that TFC parents are highly skilled and therefore, training appears to be a vital component of the TFC model. Additionally, research conducted by the Center for Advanced Studies in Child Welfare indicates, "training of foster parents is linked to foster parent satisfaction, increased licensing rates, foster parent retention, placement stability and permanency."[54] The report indicates that the EBPs highlighted in this literature review (TFCO, TFTC, TFM, PCIT and IY) all require specialized foster parent training as part of their model that may contribute to these positive outcomes for foster parents. Notably, MTFC, PCIT and IY are distinguished as having "effective" training practices as defined by the scientific rating scale used by the California Evidence-Based Clearinghouse for Child Welfare. "Effective practices" are those most well-supported by scientific evidence across the EBP rating scale.

The Center's report also indicates that efficacious "elements of general foster parent training programs include: Increasing positive parent-child interactions (in non-disciplinary situations) and emotional communication skills, teaching parents to use time out and teaching disciplinary consistency. Training programs that incorporate many partners (teachers, foster parents, social workers, etc.) with clearly defined roles appear to be the most promising in producing long term change (i.e., MTFC, IY). Additionally, training that is comprehensive in nature and incorporates education on attachment, and training in behavior management methods appears promising at addressing the complex training needs of treatment foster parents."[51]

The FFTA outlines clear standards for TFC parent training and states that "training shall be a systematic, planned and documented process that includes competency-based training." The standards call for didactic training that includes "creative and engaging methods, such as self-study and shadowing."[40] Topics may include, but are not limited to, "Principles of trauma-informed care, skills and philosophies supporting effective behavior management, crisis intervention and de-escalation, parenting approaches that increase and enhance children's well-being, collaborating with the system and advocating for the child within the system and documentation practices."[40] Mention of standards around continuing educations or topic areas for refresher trainings was a noted gap in the literature.

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[54] Foster Family-based Treatment Association. (2008). Evidence-Based Practice in Foster Parent Training and Support: Implications for Treatment Foster Care Providers. Available at: https://cascw.umn.edu/wp-content/uploads/2013/12/EBPFPTrainingSupportComplete.pdf.

Support to Therapeutic Foster Care Parents

The research demonstrates that "foster parents do not feel fully supported in their role as providers to foster children and youth."[51] As such, the research provides evidence of a series of recommendations to enhance support for TFC parents. Notable areas of services and support include the provision of benefits such as health insurance that covers all of the child's medical and BH needs and sufficient stipends for foster parents, facilitation of collaborative efforts between foster parents, agency staff and biological families (including involving foster parents in treatment and service planning), provision of respite, support from agency workers and community members and integrated models of support and training.[54] Foster parent involvement in service planning has been described as "one of the strongest influences on foster parents' satisfaction,"[54] along with support and collaboration from the social worker assigned to the child and family, from mental health providers and also from family advocates.[54]

Researchers also note the importance of "having professional staff who have training regarding sensitivity and understanding toward, and who can create and support a working relationship with TFC providers."[54] For example, in a presentation delivered by a foster care agency in Philadelphia, the presenters indicated that their agency shifted their clinical model "from supervision of case managers that focused on procedural issues (e.g., paperwork) to a model which focused on performance feedback related to support of the foster parent."[55] Supervisors in this agency provide biweekly individual supervision and biweekly group supervision to case managers who provide in-home coaching to foster families. This agency describes case managers as "critical to the success of" their TFC program and note the use of "practice through modeling and role-play and ongoing performance feedback" as effective mechanisms of feedback in supervision sessions.[55]

Under FFTA's Program Standards for TFC, support for TFC parents is stand-a-lone standard which includes requirements to disclose information to foster parents regarding the needs of child placed in their home, the importance of providing respite care that is valuable to the foster parent and also clinically beneficial to the child, the requirement for program staff to be "available and responsive to foster parents at all times,"[40] access to crisis counseling, the establishment of both informal and formal support networks such as parent support groups, the provision of adequate financial support that covers the costs of a child's care in the foster parent's home and the sharing of information about community, state and national resources that will assist the foster parent to successful care for their child (Standards 59–64).[40]

Notably, EBP "models which integrate foster parent training with on-going support have been linked to foster parent satisfaction, the development and retention of effective parenting skills, reduced foster parent stress and reduced child delinquency. More importantly, these programs are consistently linked with improvements in foster children's behavior and placement permanency. These programs were also specifically designed to be implemented with children and youth with

[55] Devereux Advanced Behavioral Health. (2017). Training Foster Parents in Positive Behavior Support: A Pilot Implementation. Available at: http://www.rcpaconference.org/wp-content/uploads/2017/10/W23_Positive_Behavior.pdf.

emotional and behavioral problems; the supports provided by these programs should help to alleviate some of the strains associated with providing care for TFC children and youth."[54]

Eligibility Criteria

The research indicates that eligibility criteria for TFC differs significantly across states. Some states utilize a prescribed set of medical necessity criteria. For a state such as California, TFC eligibility is determined by "a local child welfare supervisor and a judge"[37] and in South Dakota, child welfare workers are responsible for completing the applications to determine eligibility.[37] The research notes "Nationally, the lack of uniform level-of-care criteria for out-of-home mental health care, coupled with variations in federal and state regulations, often makes it difficult to conceptualize TFC as a single service type."[35] Technical experts who participated on SAMHSA's panel to assess research about services in TFC, also noted that "No one measure meets all needs…Measures must be developmentally appropriate. Assessment measures should be selected based on an established set of criteria...There is a need for an array of accurate, sensitive measures to screen and assess youth in order to inform level-of-care placement decisions."[35]

Funding and Billing Practices for Therapeutic Foster Care

Funding for TFC varies; however, most TFC programs receive funding from Title IV-E of the Social Security Act and Medicaid.[37] Not all states bill Medicaid for TFC. Some states use state dollars to cover TFC and utilize Medicaid dollars to cover related services (e.g., therapy, psychiatric evaluations and crisis services). For those states that do bill Medicaid for TFC, the covered service definitions vary. Some states bill Medicaid to cover services such as those provided by foster homes, training for foster homes and clinical supervision of TFC homes. Other states, such as Texas, do not include TFC in their state plan but rather utilize 1915(c) HCBS waivers to pay for TFC.[35,37] Payment of TFC to provider agencies also varies from state to state but according to the report from ASPE, "comparing costs within or among states is difficult because states use different systems to define the child's level of care…States also vary in whether specific expenses are included in the daily rate or compensated as incurred."[37]

Emphasis on Well-Being

Lastly, the research consistently referenced the importance of recognizing the social and emotional well-being of children and youth as a key component of any child welfare service delivery system. In April 2012, the Administration on Children, Youth and Families (ACYF) released an information memorandum specifically regarding this issue.[56] ACYF notes "While it is important to consider the overall well-being of children who have experienced abuse and neglect, a focus on the social and emotional aspects of well-being can significantly improve outcomes for these children while they are receiving child welfare services and after their cases have closed." ACYF states that while the child welfare system focuses primarily on the safety and permanency of children and youth in foster care, the notion of well-being has not been explored or promoted effectively in child welfare delivery

[56] Administration on Children, Youth and Families. (2012). Information Memorandum. Available at: https://www.acf.hhs.gov/sites/default/files/cb/im1204.pdf.

systems. ACYF has proposed a framework of four basic domains to measure well-being: 1) Cognitive functioning, 2) Physical health and development, 3) Behavioral/Emotional functioning and 4) Social functioning. ACYF's memorandum and framework to measure well-being has been noted as a best practice by several researchers, including in the 2013 report by Laura W. Boyd, "Therapeutic Foster Care: Exceptional Care for Complex, Trauma-Impacted Youth in Foster Care."[39] Boyd states, "Regardless of whether that maltreatment originated prior to entry into the child welfare system or as an event(s) within the child welfare system, it is not enough to remove a child from the conditions of harm following complex negative events. Emotional, physical, cognitive, and social trauma must be addressed through effective treatment." FFTA also supports the ACYF's directive and has recommended that social and emotional well-being be addressed in treatment planning for children and youth in TFC under Standard 79 of the FFTA's Program Standards for Treatment in Foster Care.[40]

The results from this section were used in the comparative analysis and informed Mercer's recommendations throughout the report.

5.0.VII — COMPARISON OF ARIZONA'S TFC/HCTC CURRENT MODEL TO OTHER STATES, INCLUDING FINANCIAL REIMBURSEMENT, MEDICAL NECESSITY CRITERIA AND TRAINING CURRICULUM

Methodology

As discussed earlier in the report under Section 5.0.ii, review of DCS Licensure Requirements for HCTC and DCS Training Protocols for Professional Foster Homes, Mercer identified 13 states with which to compare Arizona's HCTC model.[57] States were selected based on a combination of factors, including: Mercer consultants' familiarity with states currently integrated or planning to integrate foster care populations and services into managed care; states recommended by AHCCCS; state's with a population size similar to Arizona; or due to the availability of materials about other TFC programs. In addition to Arizona, states included in the comparison are: Colorado, Florida, Georgia, Indiana, Massachusetts, Missouri, New York, Oregon, Tennessee, Texas, Virginia, Washington and Wisconsin.

Mercer relied on publicly available online materials to research states. Primary resources used include state regulations, policies and bulletins, manuals, contracts, RFPs and other state-developed information. Approved Medicaid State Plan documents as well as pending or approved Medicaid waivers also served as important references.

Mercer did not conduct phone outreach to states to further explore program nuances due to SOW limitations and the number of states researched. However, hyperlinks and footnotes are contained in individual state profiles within Appendix B. Profiles were developed for 13 states, for comparison to Arizona. Mercer worked with AHCCCS to define the elements contained in the comparison, which include a brief description of the TFC service name, eligible clients, provider credentials and

[57] Mercer conducted initial research on eighteen states and narrowed down the list based on the availability and utility of information found.

training, required service interventions, funding and payment, and notable program elements. Mercer sought to collect information from each state, for each category in the table; however, states vary in the availability of content for each category. Since TFC services and components may be covered by the state children's services agency and/or paid under Medicaid, profiles contain information identifying the appropriate funder. Cells marked "N/A" indicate that the category is not applicable for a state. Mercer provides overall observations regarding findings from state comparisons at the end of this section of the report.

STATE PROFILE CATEGORIES	
Service Title/Program Name	EBPs Used
Program Overview	Required Interventions/Program Elements
Medical Necessity Criteria/Program Eligibility	Medicaid Delivery System
License/Certification	Financing Sources for TFC Services
Role of County/CPA	Medicaid Provider of TFC Services
Provider Qualifications and Training	Payment Methods and Rates

Overview of TFC Models Used in States

For ease of understanding, a summary of TFC models can be found in Appendix A, which contains a brief description of the TFC service, eligible clients, provider credentials and training, required service interventions, funding and payment, and notable program elements. Summary information was gleaned from individual state profiles.

Medicaid Coverage of TFC

State approaches for Medicaid coverage of TFC were researched to understand the extent that:

- Medicaid TFC payments go directly to a qualified foster parent who delivers a covered BH service. **(None of the states researched permits this approach)**
- Medicaid TFC payments go directly to a county or CPA whereby the county or CPA operates under a Medicaid provider agreement or MCO contract as a network provider for a covered BH service. TFC parents are under contract with the county or CPA, but TFC parents do not receive direct payments from Medicaid. **(Arizona**, **Florida, Georgia, Oregon, Tennessee and Virginia)**
- Medicaid TFC payments go directly to a traditional BH services provider, which employs or contract with licensed or credentialed BH practitioners with expertise serving the foster care population. **(Colorado**, **Wisconsin, Texas and Washington)**

TFC is Not a Medicaid Covered Service

Approaches for state-only funded TFC services were also identified to understand whether the:

- State children's services agency directly pays TFC parents. **(None of the states researched permit this approach)**

- State children's services agency pays CPA for TFC services; BH providers considered part of the "treatment team," but those BH providers directly bill Medicaid for covered services. **(Indiana, Massachusetts, Missouri and New York)**

Medicaid Delivery Systems of Selected States

Medicaid delivery systems for states are reflected in the table below. Appendix B contains identical information in individual state profiles as well as footnotes that provide more details regarding delivery system structures. For purposes of this report, descriptions of delivery systems are limited to whether a state's Medicaid Serious Emotional Disturbance (SED) population and foster care population (with or without SED) is enrolled in a FFS system or enrolled in a MCO or a prepaid inpatient health plan (PIHP). Mercer also indicated whether BH benefits for children/youth with SED or those who are in the foster care system are paid FFS, through MCO or PIHP managed services arrangement; selected states represent a mix of state approaches.

As illustrated in the table below, most states' Medicaid delivery system, children/youth with SED is through a managed care arrangement and the BH benefit for children/youth with SED is through paid through managed care. Only Indiana and Missouri provide BH benefits for children/youth with SED through FFS delivery system.

Similarly, children/youth involved in foster care are largely served through a Medicaid managed care delivery system and BH services to children/youth in foster care also paid through managed care. However, Colorado and Massachusetts utilize a FFS delivery system arrangement for foster care-involved children/youth. The State of Missouri is the only state where BH benefits for children/youth in foster care are paid FFS. As discussed more in the individual state profiles, three states provide Medicaid managed care services through a specialty MCO exclusively serving the foster care population (Georgia, Texas, and Washington).

STATE	DELIVERY SYSTEM FOR SED POPULATION		FOSTER CARE DELIVERY SYSTEM	
Arizona	☐ SED in FFS	☒ SED in MCO or PIHP[58]	☐ Foster care population in FFS	☒ Foster care population in MCO
	☐ BH benefit FFS	☒ BH benefit MCO or PIHP	☐ BH benefit for foster care FFS	☒ BH benefit for foster care MCO or PIHP[59]
Colorado	☐ SED in FFS	☒ SED in MCO or PIHP	☒ Foster care population in FFS	☐ Foster care population in MCO
	☐ BH benefit FFS	☒ BH benefit MCO or PIHP	☐ BH benefit for foster care FFS	☒ BH benefit for foster care MCO or PIHP
Florida	☐ SED in FFS	☒ SED in MCO or PIHP	☐ Foster care population in FFS	☒ Foster care population in MCO
	☐ BH benefit FFS	☒ BH benefit MCO or PIHP	☐ BH benefit for foster care FFS	☒ BH benefit for foster care MCO or PIHP
Georgia	☐ SED in FFS	☒ SED in MCO or PIHP	☐ Foster care population in FFS	☒ Foster care population in MCO
	☐ BH benefit FFS	☒ BH benefit MCO or PIHP	☐ BH benefit for foster care FFS	☒ BH benefit for foster care MCO or PIHP
Indiana	☐ SED in FFS	☒ SED in MCO or PIHP	☒ Foster care population in FFS	☒ Foster care population in MCO
	☒ BH benefit FFS	☐ BH benefit MCO or PIHP	☐ BH benefit for foster care FFS	☐ BH benefit for foster care MCO or PIHP
Massachusetts	☐ SED in FFS	☒ SED in MCO or PIHP	☒ Foster care population in FFS	☒ Foster care population in MCO
	☐ BH benefit FFS	☒ BH benefit MCO or PIHP	☐ BH benefit for foster care FFS	☒ BH benefit for foster care MCO or

[58] Serious mental illness (SMI) children/youth served by specialty BH MCOs (RBHAs) responsible for physical health (PH) and BH services. Also responsible for BH crisis services for all Medicaid lines of business, not just their own enrollees. Crisis services include telephone, community-based mobile and facility-based stabilization (up to 24 hours); Non-SMI adult members and all children served by MCOs responsible for PH and BH services, except crisis.

[59] Ibid.

STATE	DELIVERY SYSTEM FOR SED POPULATION		FOSTER CARE DELIVERY SYSTEM	
				PIHP
Missouri	☐ SED in FFS	☒ SED in MCO or PIHP	☐ Foster care population in FFS	☒ Foster care population in MCO
	☒ BH benefit FFS	☐ BH benefit MCO or PIHP	☒ BH benefit for foster care FFS	☐ BH benefit for foster care MCO or PIHP
New York	☐ SED in FFS	☒ SED in MCO or PIHP	☐ Foster care population in FFS	☒ Foster care population in MCO
	☐ BH benefit FFS	☒ BH benefit MCO or PIHP	☐ BH benefit for foster care FFS	☒ BH benefit for foster care MCO or PIHP
Oregon	☐ SED in FFS	☒ SED in MCO or PIHP	☐ Foster care population in FFS	☒ Foster care population in MCO
	☐ BH benefit FFS	☒ BH benefit MCO or PIHP	☐ BH benefit for foster care FFS	☒ BH benefit for foster care MCO or PIHP
Tennessee	☐ SED in FFS	☒ SED in MCO or PIHP	☐ Foster care population in FFS	☒ Foster care population in MCO
	☐ BH benefit FFS	☒ BH benefit MCO or PIHP	☐ BH benefit for foster care FFS	☒ BH benefit for foster care MCO or PIHP
Texas	☐ SED in FFS	☒ SED in MCO or PIHP	☐ Foster care population in FFS	☒ Foster care population in MCO
	☐ BH benefit FFS	☒ BH benefit MCO or PIHP	☐ BH benefit for foster care FFS	☒ BH benefit for foster care MCO or PIHP
Virginia	☐ SED in FFS	☒ SED in MCO or PIHP	☐ Foster care population in FFS	☒ Foster care population in MCO
	☐ BH benefit FFS	☒ BH benefit MCO or PIHP	☐ BH benefit for foster care FFS	☒ BH benefit for foster care MCO or PIHP
Washington	☐ SED in FFS	☒ SED in MCO or PIHP	☐ Foster care population in FFS	☒ Foster care population in MCO
	☐ BH benefit FFS	☒ BH benefit MCO or PIHP	☐ BH benefit for foster care FFS	☒ BH benefit for foster care MCO or PIHP

STATE	DELIVERY SYSTEM FOR SED POPULATION		FOSTER CARE DELIVERY SYSTEM	
Wisconsin	☐ SED in FFS	☒ SED in MCO or PIHP	☐ Foster care population in FFS	☒ Foster care population in MCO
	☐ BH benefit FFS	☒ BH benefit MCO or PIHP	☐ BH benefit for foster care FFS	☒ BH benefit for foster care MCO or PIHP

Medical Necessity Criteria

Medical necessity and program eligibility criteria vary across states. Eleven of the fourteen total states reviewed (Arizona, Florida, Georgia, Indiana, Massachusetts, Missouri, New York, Oregon, Texas, Virginia and Wisconsin) require SED alone or in combination with other diagnostic and functional status as condition of TFC eligibility. Three other states (Colorado, Tennessee and Washington) use broader criteria.

- **Colorado:** Regulations did not specify medical necessity or clinical eligibility for TFC. Regulations only reference client eligibility related to admission criteria to residential facilities.
- **Tennessee:** TFC is not restricted to diagnosis or functional criteria and placement may be due to other factors such as being “unable to receive the parental care they need in their own home” or having “a history of moderate mental health, and behavioral concerns that require monitoring or observation to prevent an increase in severity.”
- **Washington:** “Eligibility is determined in accordance with regional procedures following assessment of service and placement options.”

Brief summaries of each state’s client eligibility requirements can be found in Appendix A, Summary of State TFC Models. Appendix B contains additional information, where available and links to source materials that further describe state’s thresholds.

Evidence-Based models and State Training Approaches

This section describes EBPs used in the delivery of TFC services and training of TFC foster parents. Best practices and training approaches used in each state are further described in individual state profiles (Appendix B). Below is an extract of those practices and the states that utilize them. It is important to note that some states identified approved a number of curricula in regulations and manuals and are too numerous to mention in this report. However, hyperlinks and footnotes in individual profiles provide additional information.

Summary of Evidence-Based Models and Selected Training Requirements

STATE	EVIDENCE-BASED MODEL USED	SELECTED TRAINING REQUIREMENTS
Colorado: Treatment Foster Care/ TFC	An interdisciplinary stakeholder group developed a state-specific TFC model and standards, from which rules were developed by the TFC Task Group in 2017.	• **Foster parent** must annually complete 20 hours of on-going specific training. • **Treatment foster parents** must have competency-based training or documented skills and 32 hours of initial training. – Training shall include 32 hours of training in the following areas: trauma informed care, including the impact of trauma, grief and loss; trauma informed behavior management; child and/or youth-specific content; intensive mental and BH training; confidentiality and cultural responsiveness; and annual requirements for foster parents. • **Therapeutic or treatment foster parents** providing therapeutic services must complete an additional twelve hours of on-going training annually for a total 32 hours of training in such areas as dynamics of victimization issues, with emphasis on appropriate age and developmental levels; and the individual needs of the foster children/youth in care. • **Treatment foster parents** must have competency-based training or documented skills and 32 hours of initial training. – Training shall include the following areas: trauma informed care, including the impact of trauma, grief and loss; trauma informed behavior management; child and/or youth-specific content; intensive mental and BH training; confidentiality and cultural responsiveness; and annual requirements for foster parents.
Florida: Specialized TFC Services	No specific program model is identified at the state level.	• **Foster parents:** Parent Preparation Pre-service Training is required for all foster parents. Training shall be led by a child/youth protection professional certified pursuant to Section 402.40, F.S., who has a bachelor's degree or a master's degree from an accredited college or university, and who also successfully has met any curriculum-specific requirements to train the Department of Children and Families (DCF)-approved parent preparation pre-service training curriculum. DCF shall review all parent preparation pre-service training curriculum to ensure that it meets the required hours and content requirements. Continuing education for licensed out-of-home caregivers shall be offered continuing education opportunities by their supervising agency. Continuing education materials must be approved prior to use. • **Specialized therapeutic foster parent** pre-service training must be pre-approved and include at least the following areas: program orientation, including the responsibilities of

STATE	EVIDENCE-BASED MODEL USED	SELECTED TRAINING REQUIREMENTS
		the treatment parent and provider agency; normal childhood development; emotional disturbances in children/youth and common behavioral problems exhibited; behavior management, theory and skills; discipline, limit setting, logical consequences, problem-solving, and relationship building skills; communication skills; permanency planning; stress management; crisis intervention and emergency procedures; self-defense and passive physical restraint; working with biological or adoptive families; placement adjustment skills; confidentiality; cultural competency and behaviors and emotional issues of children/youth who have been sexually abused.
Georgia: TFC	The Partnership Parenting is a model used by the Division of Family and Children Services to promote shared parenting practices between caregivers and birth parents, allowing parents to continue with a measure of parenting while the child/youth is in care, so that a child's parents remain closely involved in his or her life.	• **Foster parents** receive 24-hour pre-service training[60], IMPACT, Initial Interest, Mutual Selection, Pre-Service Training, Assessment, Continuing Development and Teamwork. During the IMPACT training, families are provided with information on numerous topics to assist prospective foster parents in understanding the Division of Family and Children's Services' role in working with birth families, the roles and responsibilities of foster and adoptive parents, and the effect of abuse and neglect on children/youth and their families. • **Therapeutic foster parents:** no additional training or certification is described in the Manual specifically regarding TFC. However, there is a reference to Wraparound Services.
Indiana: TFC	All BH and related services are provided within the Child Mental Health Wraparound (CMHW) delivered using a System of Care (SOC) philosophy and consistent with Wraparound principles.	• **Foster parents** complete pre-service training, along with First Aid, CPR, and Universal Precautions training as well as 15-hours of in-service training annually. Training also includes specialized training to meet the child's specific needs. • **Foster parents with a therapeutic certification** complete 20 hours of in-service training annually, which includes 10 hours of general training and 10 hours of additional therapeutic training to meet the child's specific needs. Regional training is made available by the state. DCS also allows licensees to earn up to eight hours through alternative trainings (online trainings, books, videos, etc.).
Massachusetts: Intensive Foster	Massachusetts established IFC models of care	All **foster parents**, including **intensive foster parents**, must complete a Massachusetts MAPP training course. MAPP training

[60] AdoptUSKids. Georgia foster care and adoption guidelines. Available at: https://www.adoptuskids.org/adoption-and-foster-care/how-to-adopt-and-foster/state-information/georgia.

STATE	EVIDENCE-BASED MODEL USED	SELECTED TRAINING REQUIREMENTS
Care (IFC)	designed to address children's unique needs: • Child Home-Based Rehabilitation, • Emergency Shelter Homes, • Multiple Acute A, • Multiple Acute B, • Sexually Exploited Youth Services, • Transition to Adulthood Services, and • Transition to Adult Services.	is broken down into three-hour classes occurring once or twice a week for several weeks, for a total of 30 hours of training. Topics discussed in the MAPP program include: • Communication, • Positive discipline, • Child guidance, and • Building self-esteem.
Missouri: TFC	No specific program model is identified at the state-level.	**TFC parents** are trained and supported to implement key elements of treatment in the context of the family and community life while promoting the goals of permanency planning for youth in their care.
New York: Treatment Foster Care	• Provider agencies may choose their own model of TFC. One provider agency in Erie County described their plans to expand TFC services using the Mockingbird Family Model. • Another agency in Erie County described using the Coached Visitation Model, which is based on the research and publications of Marty Beyer and was originally promoted by New York City's Administration for Children's Services.	• Many counties and agencies use the MAPP/Group Preparation and Selection Pre-Certification Training Program for **foster parents**; counties also use the MAPP approach. • The state requires **TFC parents** to be trained in the Problem Solving Therapy — Primary Care (PST-PC) BH model. PST-PC is a therapy approach used to treat depression and anxiety in a primary care environment. The approach is composed of six to ten 30-minute sessions to help patients solve the "here and now" problems contributing to their mental health concerns. • In addition, **TFC parents** must complete a 30-hour MAPP training program and 12–15 additional hours of training annually.
Oregon: TFC	The state uses the TFC Model, which varies based on the type of care provided or the setting of the child/youth: Shelter Assessment and Evaluation, Intensive Community Care, Independent Living Service,	• **Certified foster parents** must complete Foundations training before or within 12 months after the date on which the certificate was issued. • A certified family is exempt from this requirement if a written, individualized training plan, specific to the needs of the child or young adult in the care or custody of the Department placed in the home, has been approved by the state or CPA.

STATE	EVIDENCE-BASED MODEL USED	SELECTED TRAINING REQUIREMENTS
	Community Step-Down, and Independent Living Program; TFC, Behavior Rehabilitation Services (BRS) Proctor and MTFC; BRS Proctor Day Treatment; BRS Basic Residential, BRS Rehabilitation Services; Intensive Rehabilitation Services, BRS Residential, BRS Enhanced, Short-Term Stabilization Program; and Enhanced TFC.	– The written individualized training plan: › Must be designed to strengthen the ability of the certified family to meet the safety, health, and well-being needs of the child or young adult in the care or custody of the Department placed in the home; › May be less than the required 30 hours required during a certification period; and › Must be approved by a certification supervisor. • The state may require a certified family to complete more than the 30 hours of training for a two-year certification period based on the needs of the child or young adult placed in the home and the knowledge, skills and abilities of the certified family.
Tennessee: TFC	• Tennessee does not mandate a specific TFC model, although an ongoing state collaborative aims to develop one. • All provider agencies adhere to a standard scope of services that specifies the responsibilities and services of both the agency and the TFC parents.	• CPAs require foster parents to participate in ongoing training including parenting techniques and discipline and the detection, intervention, prevention and treatment of child sexual abuse. • Newly approved **therapeutic foster parents** must also complete additional hours of specialized training targeted toward the population to be served (i.e., mental health, juvenile justice) prior to caring for the children/youth. – Juvenile Justice: 9 hours of Juvenile Justice Training — Parenting the Youthful Offender Curriculum – Mental Health: 15 hours of behavioral/mental health oriented training • Additionally, therapeutic foster parents will receive specialized training on the specific mental health or behavioral needs of each child/youth to be placed in their home.
Texas: Intense Foster Family Care	No specific program model is identified at the state level.	• **All caregivers**, except caregivers in foster homes verified by CPAs, must receive 50 hours of training each year. – Caregivers in foster homes verified by CPAs must meet the following requirements: › For homes with two or more caregivers, each caregiver must receive at least 30 hours of training. › For homes with one caregiver, the caregiver must receive at least 50 hours of training.
Virginia: Treatment Foster Care	• Virginia uses Intensive Care Coordination and the High Fidelity	• **Foster parents** receive pre-service training: – Pre-service training must address, but not be limited to, the following core competencies described in full in the

STATE	EVIDENCE-BASED MODEL USED	SELECTED TRAINING REQUIREMENTS
	Wraparound Model for youth with challenging BH issues and who are at-risk of out-of-home placement. • External evaluation has validated the efficacy of this model. Evaluation of a similar wraparound system in Maine has found as many as 82% were able to move to less restrictive environments after 18 months compared to 38% of the comparison group.	Local Department Resource, Foster, And Adoptive Family Home Approval Guidance.[61] • Certain curricula have been verified to meet the required competencies: Parent Resources for Information, Development and Education (PRIDE), MAPP and Parents as Tender Healers. The state supports PRIDE as the preferred curriculum. All other curricula must be approved by the state in order to satisfy the pre-service requirement. • **TFC parents** are approved by the licensed or certified CPA and trained to provide TFC services.
Washington: Treatment Foster Care	No specific program model is identified at the state level.	• Each **foster parent** must obtain 30 hours of training annually. Foster parents are required to take Medication Management training. Prior to placing a sexually aggressive youth (SAY) or physically aggressive assaultive youth (PAAY) with a foster parent(s), that foster parent(s) shall have specific training to address the safety and supervision of SAY or PAAY youth. – Foster parent training requirements are: › Orientation: in-person or online › Pre-Service training: 24 hours and a CPR course › Ongoing training: Annual training (36 hours during first 3-year licensing period; 30 hours during second 3-year licensing period; and 24 hours during all subsequent 3-year licensing periods) • The course catalog includes training for in-service, foundation and focused training topics. Training is organized according to relevance for caregivers, support staff, social workers and supervisors.

[61] Virginia Department of Social Services. (2013). Local Department Resource, Foster, and Adoptive Family Home Approval Guidance. https://dss.virginia.gov/files/division/dfs/fc/intro_page/guidance_manuals/other/gudiance_2_13.pdf.

<table>
<tr><th>STATE</th><th>EVIDENCE-BASED MODEL USED</th><th>SELECTED TRAINING REQUIREMENTS</th></tr>
<tr><td>Wisconsin: Treatment Foster Care</td><td>No specific program model is identified at the state level.</td><td>Foster parent training requirements are prescribed for each LOC:
<table>
<tr><th>Training Hours</th><th>Pre-Placement</th><th>Initial</th><th>Ongoing</th></tr>
<tr><td>Level 2</td><td>6</td><td>36</td><td>36 (+4 child-specific)</td></tr>
<tr><td>Level 3</td><td>30</td><td>24</td><td>24 (+6 child-specific)</td></tr>
<tr><td>Level 4</td><td>10</td><td>18</td><td>24</td></tr>
</table>
The Foster Parent Training requirements discussed above, can be found here: https://dcf.wisconsin.gov/fostercare/training.</td></tr>
</table>

Financial Reimbursement

As mentioned previously, states vary in the availability of content. This holds true for the reimbursement information as well. The eligibility criteria also differ, which impacts the comparability of the reimbursement information presented.

Consequently, the reimbursement structure varies as much as the program structures across the profile states. Some states are more defined than others regarding payment for TFC services and offer a single rate, while other states go into great depth to reimburse at various levels of need and/or age brackets. Each state profile contains additional detail on the relevant payment levels where applicable. The table below summarizes the rates at which TFC and/or related services are reimbursed. Rates paid are on a per day basis unless otherwise noted.

For purposes of this report, Mercer was not engaged to analyze the funding sources across the profile states. Most of the states for which information was available appeared to pay at a per day rate while a few states presented monthly rates. None of the noted daily rates include room and board costs. The reimbursement information below should be reviewed in conjunction with the individual state profiles in order to understand the complete picture of the program in each state.

STATE	DAILY COST	COMMENTS
Arizona	$161.23	Paid rate is approximately 13.5% greater than fee schedule rate of $143.28.
Colorado	$150.00	
Florida	$87.30/$135.80	Level I at $87.30 and Levels II and III at $135.80. See Appendix B, state profile, for detail.
Georgia	No Data	
Indiana	$39.40–$68.08	Per day rates for regular foster care for three TFC levels. BH Providers bill Medicaid for covered BH services, not TFC, provided to those in foster care.
Massachusetts	$117.67–$229.24	See state profile for varying level criteria.

STATE	DAILY COST	COMMENTS
Missouri	No Data	
New York	No Data	
Oregon	No Data	
Tennessee	$120.00–$300.00	See state profile for detail.
Texas	$186.42	
Virginia	$326.50–$700.00	Monthly TFC Case Management rate of $326.50. Foster maintenance rates ranging from $471–$700 monthly. See Appendix B, state profile, for detail.
Washington	$172.92–$802.30	Monthly rate. See Appendix B, state profile, for detail.
Wisconsin	$238.00–$511.00	Monthly rate. See Appendix B, state profile, for detail.

The following table represents encounter data specific to both the Arizona CMDP and non-CMDP HCTC services. Costs incurred for HCTC service spans were summarized by program and a per day cost was calculated. The resulting per day cost was compared to the S5109 code (including all applicable modifiers) contained in the AHCCCS fee schedule. The ratio of the paid/negotiated amount to the AHCCCS fee schedule is also presented in the table.

HCTC SERVICE PER MEMBER PER MONTH

Federal Fiscal Year	CMDP/ Non-CMDP	Unique User Months	HCTC Days	Paid Amount Derived	Paid Amount Per HCTC Day	Paid Amount AHCCCS Fee Schedule	AHCCCS Fee Schedule Per HCTC Day	Paid Amount % of AHCCCS Fee Schedule
FFY 2013	CMDP	2,028	52,952	$ 7,727,986	$ 145.94	$ 6,148,266	$ 116.11	125.7%
	Non-CMDP	1,064	30,348	$ 3,740,380	$ 123.25	$ 3,176,080	$ 104.66	117.8%
FFY 2013 — Summary		**3,092**	**83,300**	**$ 11,468,366**	**$ 137.68**	**$ 9,324,346**	**$ 111.94**	**123.0%**
FFY 2014	CMDP	1,906	52,068	$ 7,725,581	$ 148.37	$ 6,061,796	$ 116.42	127.4%
	Non-CMDP	907	25,742	$ 3,245,473	$ 126.08	$ 2,823,906	$ 109.70	114.9%
FFY 2014 — Summary		**2,813**	**77,810**	**$ 10,971,054**	**$ 141.00**	**$ 8,885,701**	**$ 114.20**	**123.5%**
FFY 2015	CMDP	2,056	55,167	$ 8,369,168	$ 151.71	$ 6,652,371	$ 120.59	125.8%
	Non-CMDP	1,050	25,223	$ 4,044,886	$ 160.36	$ 3,428,312	$ 135.92	118.0%
FFY 2015 — Summary		**3,106**	**80,390**	**$ 12,414,054**	**$ 154.42**	**$ 10,080,683**	**$ 125.40**	**123.1%**
FFY 2016	CMDP	2,452	68,307	$ 10,817,004	$ 158.36	$ 7,921,486	$ 115.97	136.6%
	Non-CMDP	1,209	28,398	$ 4,428,942	$ 155.96	$ 3,573,396	$ 125.83	123.9%
FFY 2016 — Summary		**3,661**	**96,705**	**$ 15,245,946**	**$ 157.65**	**$ 11,494,882**	**$ 118.87**	**132.6%**
FFY 2017	CMDP	2,399	61,629	$ 10,366,126	$ 168.20	$ 9,132,330	$ 148.18	113.5%
	Non-CMDP	1,560	40,038	$ 6,025,862	$ 150.50	$ 5,472,642	$ 136.69	110.1%
FFY 2017 — Summary		**3,959**	**101,667**	**$ 16,391,987**	**$ 161.23**	**$ 14,604,972**	**$ 143.65**	**112.2%**

A number of the states represented, reimburse services on a tiered approach based on either/both age and level of need. Therefore, theoretically, this structure does overpay for those needing fewer services but also does not underfund those in need of more intense services. This is important to assure providers are willing to accept higher acuity children/youth who might need additional support than those with lower needs. Arizona has a flat per diem rate not dependent upon level of need or age. Mercer recommends Arizona consider reviewing its HCTC child/youth data to determine appropriate banding by level of need and/or age to evaluate if it would be more cost effective to define various age/need tiers and develop relevant fee schedule rates by the resulting tiers. For example, establishing criteria tied to level of acuity and need with reimbursement based on factors such as number of years of experience (currently one year as a foster parent is required), type of children/youth served (e.g., populations requiring more specialization such as those with IDD or transition age youth), rate of successful outcomes and/or training. This might also help to ensure continued access to services, especially for children/youth with complex needs.

In addition, as noted in Section 5.0.i, Mercer recommends a more in-depth assessment of rates at the State, RBHA/CRS MCO, HCTC licensing agency and HCTC foster family level. The inclusion of training and supervision activities in the rate may be a potential system barrier that AHCCCS should evaluate. In addition, AHCCCS should consider collecting and evaluating the payment split between the HCTC licensing agencies and HCTC foster families.

SUMMARY OF OBSERVATIONS FROM STATE COMPARISONS

Mercer's review and synthesis of other states' approaches for TFC delivery revealed wide variation in licensure, training, organization, delivery and payment of services. Below are some observations, organized by comparison category used in individual state profiles, for the State's consideration as additional refinements are made for HCTC services:

- **Service Title/Program Name:** States refer to TFC as therapeutic foster care, TFC, and a myriad of other service titles. Unless a state is referring to a nationally known evidence-based model or approach, it is likely that the service is intended to meet the unique needs of a sub-population with health needs best addressed in a home or family-like setting.
- **Program Overview:** The goals of TFC services also vary, and may run the gamut from serving as a step-down placement from hospital inpatient or residential services, or serving as a short-term (i.e., 30-day crisis setting placement), or as alternative to residential placement, or a preventive service to reduce the risk of out-of-home placement.
- **Medical Necessity Criteria/Program Eligibility:** Basing TFC program eligibility on an SED diagnosis, with or without additional functional level status requirements (medical necessity), is common across most TFC services examined in this report. However, some states do permit the use of broader criteria to establish eligibility.
- **Licensure/Certification:** All states that utilize foster parents to deliver elements of TFC require licensure/approval as a foster parent as a pre-condition to being deemed eligible to deliver TFC services.
- **Role of County/CPA:** CPAs tend to play a similar role relative to the provision of TFC (i.e., delegated responsibility for license/approval of foster parents, training, deployment of case

managers). In some states, CPA have contracts with Medicaid MCOs and are empaneled as network providers of BH services.

- **Provider Qualifications and Training:** All states reviewed specify provider qualifications and training for the delivery of TFC, including where TFC requires additional pre-placement, initial or ongoing training on either child- or condition-specific topics to ensure the unique needs of children/youth are addressed. In Florida, TFC parents are required to be formally linked to a psychiatrist to be eligible for the provision of TFC.
- **EBPs Used:** Not all states use any prescribed model of TFC. Some states develop home-grown approaches that have been adopted/adapted by states (e.g., MAPP, TFC Oregon) while other states rely on required training topics to shape delivery of TFC.
- **Required Interventions/Program Elements:** Most states describe minimal interventions to be provided as part of a TFC services, including skills building, coping/crisis management, and de-escalation. States that permit Medicaid payment for TFC specify additional coverage requirements.
- **Medicaid Delivery System:** As depicted in the table of delivery systems, states are increasingly including the foster care population and BH services provided to them through managed care arrangements.
- **Financing Sources for TFC Services:** Funding sources for TFC include state general funds and Medicaid, in addition to IV-E. However, not all states cover TFC under Medicaid.
- **Medicaid Provider of TFC Services:** TFC services may be rendered by a foster parent or other licensed/credentialed practitioner qualified to deliver a BH service; however, payment for the service is made to the provider organization (including a CPA), but not directly to the TFC parent.
- **Payment Methods and Rates:** As the program structures across the profile states vary, so do payment methodologies and rates. States typically provide for tiered foster care maintenance rates depending upon the needs of the child/youth, however the additional reimbursement for TFC type services varies widely. Examples include: 1) payment of a flat daily rate for TFC type services; 2) Payment of tiered daily rates for TFC services based on level of need and/or age; 3) Stipend or ‘exceptional’ add-on payments; 4) Monthly case management add-on; 5) No specific TFC service rates but providers bill Medicaid for related BH services. Each state profile contains additional detail on the relevant payment methodologies and levels where applicable and should be read in conjunction with the information provided in the financial reimbursement earlier in this section of the report.

Understanding that policies are in the process of being updated, consolidated or drafted in preparation for the launch of integrated plans as of October 1, 2018, Mercer offers the following recommendations based on the review of other states' TFC services:

1. **Develop Issue Briefs for MCOs:** Describe current environment, barriers, stakeholder feedback and solicit MCO best practices for implementing/monitoring TFC in other states.
2. **Encourage Use of tiered TFC Payments:** Summarize TFC payment strategies used in other states and encourage plans to establish tiered rates based on stratified patient populations, expertise of TFC parents, or both.
3. **Implement Value-Based Payment Approaches:** Develop potential approaches that plans can use to incentivize TFC parent participation and retention.

MERCER (US) INC.
2325 East Camelback Road, Suite 600
Phoenix, AZ 85016
www.mercer.com

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APPENDIX A

SUMMARY OF STATE THERAPEUTIC FOSTER CARE MODELS

STATE: TFC NAME	ELIGIBLE CLIENTS	TFC PROVIDER CREDENTIALS AND TRAINING	TFC SERVICE INTERVENTIONS	FUNDING AND PAYMENT	NOTABLE PROGRAM ELEMENTS
Arizona: Home Care Training to Home Care Client (HCTC)/Therapeutic Foster Home	Children with special behavioral health (BH) needs.	• Licensed foster home with documentation of certification to provide specialized services as a Therapeutic Foster Home. • Specialized training around the child's BH needs and safe use of medications.	Therapeutic interventions (e.g., anger management, crisis de-escalation, psychosocial rehabilitation, living skills training and behavioral intervention) in addition to basic parenting functions (i.e., custodial care and support services).	• HCTC is a Medicaid covered service. • Medicaid reimbursement is billed using an age-specific HCTC code and modifier (S5109).	Beginning 10/1/18 foster care population will be enrolled in managed care organizations (MCOs).

STATE: TFC NAME	ELIGIBLE CLIENTS	TFC PROVIDER CREDENTIALS AND TRAINING	TFC SERVICE INTERVENTIONS	FUNDING AND PAYMENT	NOTABLE PROGRAM ELEMENTS
Colorado: Treatment Foster Care/ Therapeutic Foster Care (TFC)	No specified medical necessity criteria. TFC is part of the out-of-home continuum and can be an alternative to residential care or serve as a step-down to residential care.	• Family foster care certified by county or child placing agency (CPA). • Additional TFC training for therapeutic and treatment foster parents. • CPA care coordinators complete 40 hours of competency-based training prior to taking on a TFC caseload.	Skills building and support services in a nurturing and individualized family environment.	• CPAs are paid a daily foster care rate for TFC. • Medicaid managed Behavioral Health Organizations (BHOs) pay network providers for covered BH treatment services. • BHOs receive a Foster Care Capitation rate.	• Children in foster care are mandatorily enrolled in BHOs. • BHOs pay only for the treatment portion of TFC and do not pay foster care parent. Foster parents are paid by county or CPA for custodial care.

STATE: TFC NAME	ELIGIBLE CLIENTS	TFC PROVIDER CREDENTIALS AND TRAINING	TFC SERVICE INTERVENTIONS	FUNDING AND PAYMENT	NOTABLE PROGRAM ELEMENTS
Florida: Specialized Therapeutic Foster Care Services (STFC)	• Children with a history of abuse/ neglect, or delinquent behavior and who have an emotional disturbance or serious emotional disturbance (SED). • Higher levels of STFC require additional level of care needs to be met.	• Highly trained specialized therapeutic foster parents who provide services through a CPA. • STFC pre-training must be pre-approved by Department of Children and Families (DCF) or its designee or by an MCO for their network providers.	Close supervision and clinical interventions within the TFC. During a crisis intervention services are provided to stabilize a behavioral, emotional or psychiatric crisis.	Medicaid pays for two levels of STFC, including when the service is used as a temporary crisis intervention setting.	• STFC parents must be linked to a treating psychiatrist and a primary care clinician. • STFC providers must complete an Agency Self-Certification, which requires the signature from DCF or its designee.

STATE: TFC NAME	ELIGIBLE CLIENTS	TFC PROVIDER CREDENTIALS AND TRAINING	TFC SERVICE INTERVENTIONS	FUNDING AND PAYMENT	NOTABLE PROGRAM ELEMENTS
Georgia: Therapeutic Foster Care	Youth has an SED and at least one other specified level of care criteria.	All foster parents receive Parent Preparation Pre-service Training led by a child protection professional certified pursuant to State law, and who also successfully has met any curriculum-specific requirements to train the DCF-approved parent preparation pre-service training curriculum.	Crisis intervention, intensive supporting resources management, counseling and other rehabilitative supports.	Services are paid by MCOs to eligible providers and not to foster parents.	• Maximum length of initial authorization is 90 days. • Concurrent authorization is also 90 days.

STATE: TFC NAME	ELIGIBLE CLIENTS	TFC PROVIDER CREDENTIALS AND TRAINING	TFC SERVICE INTERVENTIONS	FUNDING AND PAYMENT	NOTABLE PROGRAM ELEMENTS
Indiana: Therapeutic Foster Care	• Children 5–18 with a score of 3 on the Child and Adolescent Needs and Strengths (CANS) placement decision model. • A CANS score of 4–7 qualifies the child to be eligible for Therapeutic Plus Foster Care.	Licensed foster parent with a therapeutic certification, which requires additional annual in-service hours.	A CANS assessment is required every 180 days.	• CPA pays TFC providers for age-specific rates. • No Medicaid payment for TFC services. Medicaid providers (including CPAs with provider agreements) bill for covered BH treatment services.	State operates under a children's system of care model and requires child mental health wraparound (CMHW) service providers to have 2–3 years of experience working with SED population.
Massachusetts: Intensive Foster Care (IFC)	Children birth to age 22 who may have a range of behavioral and cognitive needs and for whom traditional foster care is not sufficiently supportive.	Licensed foster parent with applicable training and extensive foster home experience based on the level of care required by the child.	Interventions specific to individual needs of children in a level of care.	• DCF defines two IFC program types and several levels of care in which a child may be placed. • DCF established payment rates for each program type and care level. • No Medicaid payment for IFC services.	• Statewide training method: Massachusetts Approach to Partnership in Parenting (MAPP). • Rate structure includes a stipend, an operational service rate and a teen parent rate.

STATE: TFC NAME	ELIGIBLE CLIENTS	TFC PROVIDER CREDENTIALS AND TRAINING	TFC SERVICE INTERVENTIONS	FUNDING AND PAYMENT	NOTABLE PROGRAM ELEMENTS
Missouri: Therapeutic Foster Care	Children 6–21 who have severe behavioral disorders, psychiatric diagnoses, delinquency and symptoms of complex trauma.	Licensed foster parents with special training and support to implement key elements of treatment in the context of the family.	Teaching pro-social skills and responses that equip families with means to deal with unique conditions or circumstances that created the need for treatment.	• The Department of Social Services pays a TFC maintenance payment for the service. • Online information notes that "Medicaid allowed," but it is not clear to what that payment notation occurs.	Each therapeutic foster home and child is assigned a TFC worker by the CPA that provides support to TFC foster parents, families, and other treatment team members.

STATE: TFC NAME	ELIGIBLE CLIENTS	TFC PROVIDER CREDENTIALS AND TRAINING	TFC SERVICE INTERVENTIONS	FUNDING AND PAYMENT	NOTABLE PROGRAM ELEMENTS
New York: Treatment Foster Care	Children and youth up to age 21 (with a minimum IQ of 65) who have moderate to severe behavioral issues and emotional conditions and can be supported within a family setting.	• Foster homes are "certified" (the term used for non-relative homes) or "approved" (the term used for relatives) by the state according to the same standards. • To deliver TFC, the state requires all foster parents to be trained in the Problem Solving Therapy-Primary Care BH model in addition to MAPP training.	Interventions vary based on the unique needs of each child.	• Title IV-E funds pay room and board for eligible children. • Medicaid funding supports therapeutic services for children.	• TFC is a state-supervised, locally administered service, which mirrors the state's decentralized child welfare structure. • Average placement in TFC setting is twelve months. • Counties have discretion to supplement state rates. New York City uses funds from a city tax levy for this purpose.

STATE: TFC NAME	ELIGIBLE CLIENTS	TFC PROVIDER CREDENTIALS AND TRAINING	TFC SERVICE INTERVENTIONS	FUNDING AND PAYMENT	NOTABLE PROGRAM ELEMENTS
Oregon: Therapeutic Foster Care	Children in need of remediating debilitating psychosocial, emotional and behavioral disorders through behavioral intervention, counseling and skills training in a TFC setting.	• Two-year foster parent certifications and approvals are issued by the Department of Human Services. • TFC parents receive initial and annual training plus annual training.	Service interventions are based on the appropriate TFC model and setting consistent with the needs of the child (e.g., behavior management, intensive structure, skills training, etc.)	Medicaid pays for TFC for members under age 21 through billing code S5146.	The Medicaid-funded services do not require the child to be in the foster care system.
Tennessee: Therapeutic Foster Care	Children/youth unable to receive parental care in their own home but capable of participating in a family unit. May have a history of moderate mental health and behavioral concerns.	Licensed foster care programs that are reevaluated annually. TFC parents received specialized training targeted toward the population served.	• Assist child in receiving outpatient therapy; assist and support child in receiving medication management. • Provide recreational activities, assist in development of daily living and interpersonal skills, and support achievement of permanency goals.	• TFC financed through Department of Children's Services (DCS) and TennCare. • Medicaid funds are used only to pay for covered clinical and therapeutic services.	TennCare contracts with DCS to provide funding for all children in custody as well as for pre-custodial investigative work.

STATE: TFC NAME	ELIGIBLE CLIENTS	TFC PROVIDER CREDENTIALS AND TRAINING	TFC SERVICE INTERVENTIONS	FUNDING AND PAYMENT	NOTABLE PROGRAM ELEMENTS
Texas: Intense Foster Family Care	Children who need intense services and have severe problems in one or more areas of functioning (e.g., self-injurious actions, substance use disorder) and able to be served in a family setting.	Previous experience in residential childcare or 40 hours of supervision while conducting direct childcare duties. Foster home caregivers must receive annual training.	Consistent and frequent attention, direction, and assistance to help the child achieve stabilization and connect appropriately with the child's environment.	• TFC is a BH benefit under the STAR Health Foster Care Program for children in the Texas foster care system. • Foster parents do not receive payment for services. Rather, eligible providers enrolled in Medicaid (who may employ/contract with foster parents through local agencies) receive payments.	• Training requirements for caregivers in TFC homes with two or more caregivers are lower (30 hours of training) as compared with settings with only one caregiver (50 hours). • Interventions for children with development delays are also specified (e.g., self-help skills, mobility, communication, etc.).

STATE: TFC NAME	ELIGIBLE CLIENTS	TFC PROVIDER CREDENTIALS AND TRAINING	TFC SERVICE INTERVENTIONS	FUNDING AND PAYMENT	NOTABLE PROGRAM ELEMENTS
Virginia: Treatment Foster Care	CANS assessment indicates TFC appropriateness and Virginia Enhanced Maintenance Tool indicates need for high-level daily supervision.	TFC parents are approved by the licensed or certified child-placing agency and trained to provide treatment foster care services.	Support in implementing the treatment and service plan for the child and arrange for the child to receive recommended or identified clinical services (e.g., psychiatric, psychological, medication management).	• BH services for children in foster care are managed and paid through the Community BH Services Program, a pre-paid inpatient health plan. • Children in foster are mandatorily enrolled in Community Behavioral Health Services Programs (but may voluntarily enroll in traditional MCOs for non-BH services).	• Virginia also prescribes TFC case management as a component of treatment foster care. • Permanency planning and other activities by foster care workers are not Medicaid reimbursed activities.

STATE: TFC NAME	ELIGIBLE CLIENTS	TFC PROVIDER CREDENTIALS AND TRAINING	TFC SERVICE INTERVENTIONS	FUNDING AND PAYMENT	NOTABLE PROGRAM ELEMENTS
Washington: Treatment Foster Care	Eligibility is determined, in accordance with regional procedures, following assessment of service and placement options.	Foster care license for three-year period. Licensure requires orientation, pre-service, and ongoing annual training using pre-approved curricula.	Varies based on level of service and unique needs of the child.	The Washington State Department of Social and Health Services — Children's Administration established four levels of foster care reimbursement.	• Training is organized according to relevance for caregivers, support staff, social workers and supervisors. • Ongoing annual training requirements decrease for each subsequent licensure period. • Children in foster care are enrolled in the Washington State Apple Health Foster Care managed care program.

STATE: TFC NAME	ELIGIBLE CLIENTS	TFC PROVIDER CREDENTIALS AND TRAINING	TFC SERVICE INTERVENTIONS	FUNDING AND PAYMENT	NOTABLE PROGRAM ELEMENTS
Wisconsin: Treatment Foster Care	CANS tool helps determine level of need and service type, and placement.	• Licensed foster homes are certified as a Level 3, 4 or 5 to provide moderate, specialized, or exceptional treatment foster care, respectively). • Pre-placement, initial and ongoing training is mandatory. • Training and experience is required for each level of care.	Interventions vary based on whether the child's needs are related to physical, medical, or personal care. TFC providers are responsible for implementing specific activities or treatments outlined in a medical plan of care.	DCF established a Uniform Foster Care Rate based on child needs. Supplemental and Exceptional Rates are paid, as appropriate, in addition to a Basic Maintenance Rate.	Some levels of care require a previous professional (i.e., clinical) relationship with the child.

APPENDIX B – STATE PROFILES

COLORADO: TREATMENT FOSTER CARE / THERAPEUTIC FOSTER CARE

CATEGORY	DESCRIPTION
Service Title/ Program Name	Treatment Foster Care/Therapeutic Foster Care (TFC)
Program Overview	**STATE CHILDREN'S SERVICES AGENCY** TFC: A program of foster care that incorporates treatment for the special physical, psychological, or emotional needs of a child placed with specially trained foster parents. Treatment Foster Care: A clinically effective alternative to residential treatment facilities that combines the treatment technologies typically associated with more restrictive settings with a nurturing and individualized family environment. The purpose of the TFC Program Rule is to formalize a structure for the program to provide consistency in services and address expectations for service delivery. TFC adds to Colorado's out-of-home care continuum of care and can be an alternative to out-of-home care in institutional or congregate care settings like a Residential Child Care Facility (RCCF). TFC can also serve as a step-down for children and youth already in an RCCF who continue to need intensive and structured interventions and would benefit from a family-like setting. The purpose of the TFC Program is to provide treatment to a child or youth in the context of a TFC home, unlike a traditional foster care home that is intended to provide nurturing and custodial care. If not served in the TFC home, the child or youth would otherwise be placed in care in a more restrictive setting, such as an RCCF due to high acuity levels of emotional, psychological, and/or behavioral symptoms presented by the child or youth. There is an expectation that stability of placement and permanency will be achieved for the following reasons: attention to compatibility of the treatment foster parent's skills and expertise with the needs of the child or youth, provision of ongoing clinical and support services are provided to the child or youth, parents, and treatment foster parents in the context of the home and community, and a treatment team provides intensive review and oversight. The preferred maximum number of children and youth in TFC that may be assigned to a care coordinator is eight, however some circumstances may allow for a larger maximum caseload size, but in no instance may it exceed 12. A treatment foster home shall not exceed two children or youth placed in the home for

CATEGORY	DESCRIPTION
	treatment, unless to allow for the placement of siblings.
	MEDICAID N/A
Medical Necessity Criteria/ Program Eligibility	STATE CHILDREN'S SERVICES AGENCY No medical necessity or clinical eligibility for TFC is defined in regulations. Licensure regulations only define child/youth eligibility for admission to residential facilities.
	MEDICAID N/A
License/ Certification	LICENSURE TYPES **Permanent License:** Remains in effect until surrendered or revoked **Time Limited License:** Expires on a date set by the Department **Provisional License:** Issued only for the initial six-month licensing period Also see DHHS Social Service Rules, Rule Manual Volume 7 Child Care Facility Licensing, 12 CCR 2509-8. STANDARD FOSTER CARE "Family foster care home", as defined at Section 26-6-102, C.R.S., means a facility that is certified by the county department or a child placement agency (CPA) for child care in a place of residence of a family or person for the purpose of providing 24-hour family care for a child under the age of 18 years who is not related to the head of such home, except in the case of relative care. The term includes any foster care home receiving a child for regular 24-hour care and any home receiving a child from any state-operated institution for child care or from any CPA. TREATMENT/THERAPEUTIC FOSTER CARE No separate licensure for TFC.

CATEGORY	DESCRIPTION
Role of County/ Child Placing Agency	SAMPLE CONTRACT **Denver RFP for Child Placing Agencies:** The purpose of the contract is to establish an agreement and scope of services between Denver Department of Human Services (DDHS) and Contractor to provide out-of-home placement services for children/youth in the custody of the Department. *"The services purchased under this Agreement may include, but are not limited to basic 24-hour care and child maintenance (food, shelter, clothing, educational supplies, personal incidentals and allowance), administrative overhead, and case management. Behavioral health (BH) services which may include but are not limited to individual, group and family therapy, in-home services and day treatment may be authorized and paid through the child's/youth's Medicaid eligibility. BH services may also be authorized and purchased directly by the City through the Core Service program. The amount paid for purchased care and services must be in writing and will be based upon the negotiated rate."*
Provider Qualifications and Training *(Including Notable Curriculum Details If Available)*	STATE CHILDREN'S SERVICES AGENCY **Foster Parent Training** Annually, each foster parent, except therapeutic foster parents or treatment foster parents, must complete twenty hours of on-going specific training as required in his/her training development plan. In addition to initial certification requirements (Section 7.708.2-7.708.52), treatment foster parents shall have competency-based training or documented skills. Initially a treatment foster parent shall have 32 hours of training in the following areas: trauma informed care, including the impact of trauma, grief and loss; trauma informed behavior management; child and/or youth-specific content; intensive mental and BH training; confidentiality and cultural responsiveness; and annual requirements for foster parents (Section 7.708.65, c, 1-9). Therapeutic or treatment foster parents providing therapeutic services must complete an additional twelve hours of on-going training annually for a total of thirty-two hours of training in such areas as dynamics of victimization issues, with emphasis on appropriate age and developmental levels; and the individual needs of the foster children in care. In addition to initial certification requirements (Section 7.708.2-7.708.52), treatment foster parents shall have competency-based training or documented skills. Initially, a treatment foster parent shall have 32 hours of training in the following areas: trauma informed care, including the impact of trauma, grief and loss; trauma informed behavior management;

CATEGORY	DESCRIPTION
	child and/or youth-specific content; intensive mental and BH training; confidentiality and cultural responsiveness; and annual requirements for foster parents (Section 7.708.65, c, 1-9). In addition, treatment foster parents must annually complete 32 hours of training described in a written training development plan, which is on record for each treatment foster parent. Training is acquired as follows: 1. Training emphasizes skill development, knowledge, acquisition, and preparation related to meeting the needs of the child or youth placed in the TFC home; 2. Program policies and procedures, ethics and cultural competency; 3. No less than 22 hours shall take place in a classroom setting or in an interactive setting so that treatment parents' strengths and supports needed, can be gauged and positive relationships can be developed between program staff and treatment foster parents, as well as between/among treatment foster parents; and 4. Training hours received for first aid and cardiopulmonary resuscitation (CPR) shall not be included in the required 32 hours of annual training. A description of courses available to foster parents is at https://coloradocwts.com/find-a-class-families/foster-course-catalog. Training topics are: • The Birds, the Bees, and the Stork • Child Development and the Effects of Trauma: Adolescent Development (Web Based Training) • Child Development and the Effects of Trauma: Infant and Toddler Development (Web-Based Training) • Child Development and the Effects of Trauma: School Age Child Development (Web-Based Training) • Child Development and the Effects of Trauma: The Essentials (Web-Based Training) • Child Welfare Response to Child & Youth Sex Trafficking: Module 4 for Caregivers • Consequences of Maltreatment for Child Development • Creating Healing Attachments for Children • Credit Education for Youth in Foster Care • Foster Parent CORE Training • The Invisible Conversation • Legalized Marijuana: Considerations for Child Safety (Web-Based Training) • Legal Preparation for Foster Parents

CATEGORY	DESCRIPTION
	• Mandatory Reporter Training • Motivating Positive Outcomes with Adolescents • The Reasonable and Prudent Parent Standard (Web-Based Training) • Safe Sleep: Creating Safe Sleep Environments for Infants (Web-Based Training) • Supporting Youth in Achieving Permanency **Agency Staff Training** Applicants for a TFC program include a county department of human/social services or a CPA that is approved by the Colorado Department of Human Services (DHS). The treatment team members may include, and are not limited to: biological or adoptive parents, treatment foster parent(s), legal custodian(s), guardian ad litem, Court Appointed Special Advocate, county department of human/social services caseworker or designee, CPA staff, current or previous treatment providers, juvenile justice staff and school district personnel. Staff training: a care coordinator shall have 40 hours of competency-based training and/or documented skill in the following areas, prior to assuming responsibilities of a TFC caseload and annually thereafter: the program's treatment philosophy and the specific treatment methodologies the program uses; trauma informed care; strategies to maintain placement stability in TFC home; rights of children and youth in TFC in the education system and special education programs; TFC rules; and program policies and procedures. MEDICAID None identified in Medicaid policies or regulations. May be defined by individual behavioral health organizations (BHOs).
Evidence-Based Practices Used *(if applicable)*	From July 2012–October 2013, a TFC Task Group convened with members from Aspen Pointe Mental Health, Colorado Association for Children and Families Agencies — a networking group of CPAs and RCCFs, Colorado DHS, Colorado State Foster Parent Association, county departments of human/social services, CPAs, Foster Care and Adoption Agencies of Colorado (a networking group of CPAs, now called Fostering Colorado), Health Care Policy and Financing and the Office of Behavioral Health. Two BHOs (Access and Behavioral Healthcare, Incorporated) participated in several subcommittees. A subcommittee met intermittently from February–June 2014. A TFC model and standards were recommended and a Memorandum of Understanding was

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<tr><th>CATEGORY</th><th colspan="6">DESCRIPTION</th></tr>
<tr><td></td><td colspan="6">developed.

From November 2014–June 2016, five county departments of human/social services (Boulder, Denver, El Paso, Garfield and Weld) and eight CPAs (Ariel Clinical Services, Chins Up/Griffith Center, Kids Crossing, Lutheran Family Services-Rocky Mountain, Maple Star of Colorado, SAFY of Colorado, Savior House and Shiloh House) partnered in a TFC pilot with varying levels of participation. A six-week TFC Task Group convened from January 27–March 10, 2017 to develop rules.</td></tr>
<tr><td>Required Interventions/ Program Elements</td><td colspan="6">BHOs must demonstrate an adequate number of providers who can provide treatment for children in foster care, which includes clinicians who are experienced in working with the child welfare system. This shall be reported on the network adequacy reports by indicating providers who are proficient with TFC.

BHOs are responsible for the treatment portion of TFC and not responsible for the selection and payment of the foster care parent, which is provided by the county DHS.</td></tr>
<tr><td rowspan="3">Medicaid Delivery System[1]</td><td colspan="3">Delivery System for Serious Mental Illness(SMI)/Serious Emotional Disturbance (SED)</td><td colspan="3">Delivery System for Foster Care</td></tr>
<tr><td colspan="2">☐ SED population in fee-for-service (FFS) system</td><td colspan="2">☒ SED population enrolled in managed care</td><td>☒ Foster care population in FFS system</td><td>☐ Foster care population enrolled in managed care</td></tr>
<tr><td colspan="2">☐ BH benefit managed FFS</td><td colspan="2">☒ BH benefit managed by Managed Care Organization (MCO) or PIHP</td><td>☐ BH benefit for children in foster care managed FFS</td><td>☒ BH benefit for children in foster care managed by MCO or PIHP</td></tr>
<tr><td>Financing Sources for TFC Services</td><td>☒ IV-E</td><td>☒ Medicaid Treatment (including</td><td>☐ Medicaid Administrative</td><td>☐ State General Fund</td><td>☐ County</td><td>☐ Other</td></tr>
</table>

[1] Children in foster care may voluntarily enroll in Medicaid managed care. However, children in foster care are mandatorily enrolled in the Community Behavioral Health Services Program, the BH benefit managed by Prepaid Inpatient Health Plans (PIHPs). BHOs provide BH services as a separate carve-out plan. BHOs are responsible for coordination of care for children with special health care needs, including children in foster care or at risk of out-of-home placement.

CATEGORY	DESCRIPTION					
		TCM)				
Medicaid Provider of TFC Services *(if applicable)*	☐ State/ County Children's Agency	☐ Child Placing Agency	☒ Foster Parent	☐ BH Services Organization/ Clinician	☐ Waiver Case Management Entity	☐ Not Applicable or Other
Payment Methods and Rates for TFC Services *(if applicable)*	STATE CHILDREN'S SERVICES AGENCY The federal government will reimburse Title IV-E eligible and claimable children and youth in treatment foster care. Federal reimbursement is approximately 50% for Title IV-E eligible children and youth. Approximately 50% of children and youth are eligible and claimable. The state Medicaid plan allows billing for certain clinical services when medical necessity criteria are met. County departments that contract for treatment foster care will pay lower or similar daily costs for treatment foster care in comparison to RCCF, $150.00 vs. $179.00 respectively. Both types of care will also bill Medicaid for certain services, as long as medical necessity criteria are met. The daily rate for treatment foster care rate for CPAs is assumed to be approximately $150.00 per day. This includes fees for child maintenance, administrative maintenance, and administrative services (when placed in a CPA). The county departments of human/social services and CPAs have the ability to negotiate the rate upward or downward. If a county department of human/social services provides treatment foster care, foster care maintenance is the only fee that is paid. County departments of human/social services and the State of Colorado will bear the cost of treatment foster care for the long-term. County foster care programs and CPAs whose foster parents transition to become treatment foster parents will experience a reduction in traditional foster care homes, as well as the number of children and youth that can be served in those homes, which will result in a need to recruit more traditional foster care homes. Recruiting and supporting treatment foster care homes will increase workload for county departments and CPAs that choose to have a treatment foster care program.					

CATEGORY	DESCRIPTION
	MEDICAID Rates below are not for TFC services, but reflect the capitation payments made to BHOs. TFC-specific payment rates were not listed in materials reviewed.

BHO MONTHLY CAPITATION RATE	MENTAL HEALTH RATE	SUBSTANCE USE DISORDER (SUD) RATE
Elderly	$ 11.71	$ 0.02
Disabled	$ 154.62	$ 154.62
Adult	$ 21.72	$ 1.91
Children	$ 16.80	$ 16.80
Foster Care	$ 219.39[2]	$ 1.27

[2] Medicaid BH Expansion per member per month rate for foster care is $187.08.

FLORIDA: SPECIALIZED THERAPEUTIC FOSTER CARE SERVICES

CATEGORY	DESCRIPTION
Service Title/ Program Name	Specialized Therapeutic Foster Care Services (STFC)
Program Overview	**STATE CHILDREN'S SERVICES AGENCY** N/A
	MEDICAID **STFC Services:** STFC services are intensive treatment services provided to recipients under the age of 21 years with emotional disturbances who reside in a state licensed foster home. STFC services are appropriate for long-term treatment and short-term crisis intervention.[3] The goal of STFC is to enable a recipient to manage and to work toward resolution of emotional, behavioral or psychiatric problems in a highly supportive, individualized and flexible home setting. STFC services incorporate clinical treatment services, which are behavioral, psychological and psychosocial in orientation. Services must include clinical interventions by the specialized therapeutic foster parent(s), a primary clinician and a psychiatrist. A specialized therapeutic foster parent must be available 24-hours per day to respond to crises or to provide special therapeutic interventions. There are two levels of STFC, which are differentiated by the supervision and training of the foster parents and intensity of programming required. STFC levels are intended to support, promote competency, and enhance participation in normal, age-appropriate activities of recipients who present moderate to serious emotional or behavior management problems. Programming and interventions are tailored to the age and diagnosis of the recipients. STFC services are offered at Level I or Level II, with crisis intervention available at both levels. Level I STFC is characterized by close supervision of the recipient within a specialized therapeutic foster home. Services to the recipient must include clinical interventions by

[3] Specialized Therapeutic Services Coverage and Limitations Handbook, Agency for Health Care Administration, March 2014.

CATEGORY	DESCRIPTION
	the specialized therapeutic foster parent(s), a primary clinician and a psychiatrist. Level II STFC is characterized by the need for more frequent contact between the specialized therapeutic foster parents, the recipient, primary clinician and the psychiatrist as a result of the recipient exhibiting the maladaptive behaviors. Level II STFC is intended to provide a high degree of structure, support, supervision and clinical intervention. **Crisis Intervention Services:** STFC services may be used for a maximum of 30 days for crisis intervention for a recipient for whom services must occur immediately in order to stabilize a behavioral, emotional or psychiatric crisis. Any exception to this length of stay must be approved in writing by the multidisciplinary team. A Comprehensive Behavioral Health Assessment (CBHA) must be initiated within 10 working days of crisis intervention services for any recipient who has not had a CBHA in the past year.
Medical Necessity Criteria/ Program Eligibility	STATE CHILDREN'S SERVICES AGENCY N/A
	MEDICAID Level I STFC is for recipients with a history of abuse or neglect, or delinquent behavior, and who have an emotional disturbance or serious emotional disturbance. The recipient must qualify for foster care and must meet at least one of the following criteria: (1) requires admission to a psychiatric hospital, a crisis stabilization unit or a residential treatment center without STFC, or (2) within the last two years, been admitted to one of these treatment settings. A recipient requiring Level II STFC must meet the following criteria: meet the criteria of Level I STFC; be exhibiting more severe maladaptive behaviors (e.g., destruction of property, physical aggression toward people or animals, self-inflicted injuries, suicidal ideations or gestures, an inability to perform activities of daily and community living due to psychiatric symptoms). The recipient must require the availability of highly trained specialized therapeutic foster parents as evidenced by at least one of the behaviors or deficits listed above. **Crisis Intervention Services:** The recipient must be in foster care or delinquent and must be determined by the multidisciplinary team to meet Level I or Level II criteria.
License/ Certification	LICENSURE TYPES **Standard Foster Care**

CATEGORY	DESCRIPTION
	Licensed out-of-home caregivers meeting the criteria of Section 409.175, F.S., may be issued a license for longer than one year, but no longer than three years. Re-licensure is required for a three-year period. TREATMENT/THERAPEUTIC FOSTER CARE N/A
Role of County/ Child Placing Agency	SAMPLE CPA CONTRACT The agreement sets out procedures to be used by the Department of Regional Foster Care Licensing Program Management and the Lead Agency staff when processing applications and renewals for foster care licenses. Lead agency responsibilities are contained in the agreement.
Provider Qualifications and Training *(Including Notable Curriculum Details If Available)*	STATE CHILDREN'S SERVICES AGENCY **Foster Parent Training** **Parent Preparation Pre-service Training:** Each parent preparation pre-service training class shall be led by a child protection professional certified pursuant to Section 402.40, F.S., who has a bachelor's degree or a master's degree from an accredited college or university, and who also successfully has met any curriculum-specific requirements to train the Department of Children and Families (DCF)-approved parent preparation pre-service training curriculum. DCF shall review all parent preparation pre-service training curriculum to ensure that it meets the required hours and content requirements. **Continuing Education:** Licensed out-of-home caregivers shall be offered continuing education opportunities by their supervising agency. Continuing education materials must be approved prior to use.
	MEDICAID Specialized therapeutic foster parent pre-service training must be approved by the DCF or their designee or by a managed care plan for their network providers. The specialized therapeutic foster parent pre-service training must address at least the following areas: program orientation, including the responsibilities of the treatment parent and provider agency; normal childhood development; emotional disturbances in children and common behavioral problems exhibited; behavior management, theory and skills; discipline, limit-setting, logical consequences, problem-solving, and relationship building skills; communication skills; permanency planning; stress management; crisis intervention and emergency procedures; self-defense and passive physical restraint; working with biological or adoptive families; placement adjustment skills; confidentiality; cultural competency and behaviors and emotional issues of children who have been sexually abused Agency staff

CATEGORY	DESCRIPTION			
	training.			
Evidence-Based Practices Used *(if applicable)*	No specific program model is identified at the state level. Providers must be linked to a treating psychiatrist. Specialized therapeutic foster care providers must complete the Specialized Therapeutic Foster Care Provider Agency Self-Certification. This self-certification also requires the signature of DCF or its designee. Providers must submit the completed self-certification to the Medicaid fiscal agent with their enrollment application.			
Required Interventions/ Program Elements	*See* Provider Qualifications.			
Medicaid Delivery System[4]	**Delivery System for SMI/SED**		**Delivery System for Foster Care**[5]	
	☐ SED population in FFS system	☒ SED population enrolled in managed care	☐ Foster care population in FFS system	☒ Foster care population enrolled in managed care
	☐ BH benefit managed FFS	☒ BH benefit managed by MCO or PIHP	☐ BH benefit for children in foster care managed FFS	☒ BH benefit for children in foster care managed by MCO or PIHP

[4] Florida has transitioned to a delivery model wherein the majority of fully Medicaid eligible recipients receive their services through a health plan. The statewide Medicaid Managed Care program was fully implemented in August 2014 and has two components: The Managed Medicaid Assistance (MMA) program and the Long-term Care program. The Agency operates the MMA program through an 1115 waiver. The DCF Office of Substance Abuse and Mental Health serves as the single state authority for mental health and substance abuse services. Florida law requires DCF to implement a SOC to provide substance abuse treatment and mental health services. The Child Welfare Specialty plan is designed to provide services to Florida Medicaid-eligible recipients under the age of 21 years who have an open case in the Florida Safe Families Network. In 2015, Florida law was amended to allow Florida Medicaid-eligible children who are in subsidized adoptions to enroll in the Child Welfare Specialty plan. The Agency contracted with Sunshine Health as a statewide specialty plan to serve the child welfare population. All MMA plans, including the Child Welfare Specialty plan, are responsible for covering comprehensive medical and BH services. All MMA plans, including the Child Welfare Specialty plan, are responsible for also covering the following SIPP, Behavioral Health Overlay Services, Substance Abuse Services, Targeted Group Care Services, STFC services and CBHA. Many of these services have historically only been available through fee for-service Medicaid.

[5] Children in foster care may voluntarily enroll in Medicaid managed care. However, children in foster care are mandatorily enrolled in the Community Behavioral Health Services Program, the BH benefit managed by PIHPs.

CATEGORY	DESCRIPTION					
Financing Sources for TFC Services	☐ IV-E	☒ Medicaid Treatment (including TCM)	☐ Medicaid Administrative	☐ State General Fund	☐ County	☐ Other
Medicaid Provider of TFC Services *(if applicable)*	☐ State/ County Children's Agency	☐ Child Placing Agency	☒ Foster Parent	☒ BH Services Organization /Clinician	☐ Waiver Case Management Entity	☐ Not Applicable or Other

Payment Methods and Rates for TFC Services *(if applicable)*

STATE CHILDREN'S SERVICES AGENCY

Effective January 1, 2018, the minimum room and board rates paid to foster parents are as follows:

- 0–5 Years: $457.95
- Age 6–12: $469.68
- Years Age 13–21: $549.74

Foster parents will receive an annual cost of living increase. If a young adult is residing in a foster home, room and board rate payments are paid directly to the foster parent.

Unable to identify amount of Specialized TFC add-on rate (if any) paid by the state or county children's services agency.

MEDICAID

	CODE/ MODIFIER	MAXIMUM FEE	LIMITATIONS
Specialized Therapeutic Foster Care, Level I	S5145	$87.30 per day	Medicaid will not reimburse a provider for days when a recipient is in a Juvenile Justice detention center. The community BH services psychosocial rehabilitation and clubhouse will not be reimbursed as a separate service by Medicaid for recipients receiving STFC services.
Specialized Therapeutic Foster Care, Level II	S5145/HE	$135.80 per day	
Specialized Therapeutic Foster Care, Crisis Intervention	S5145/HK	$135.80 per day	

CATEGORY	DESCRIPTION

GEORGIA: THERAPEUTIC FOSTER CARE

CATEGORY	DESCRIPTION
Service Title/ Program Name	Georgia Families 360 — Intensive Family Intervention/Therapeutic Foster Care[6]
Program Overview	STATE CHILDREN'S SERVICES AGENCY A service intended to improve family functioning by clinically stabilizing the living arrangement, promoting reunification or preventing the utilization of out-of-home therapeutic venues (i.e., psychiatric hospital, psychiatric residential treatment facilities or residential treatment services) for the identified youth. Services are delivered utilizing a team approach and are provided primarily to youth in their living arrangement and within the family system. Services promote a family-based focus in order to: • Defuse the current BH crisis, evaluate its nature and intervene to reduce the likelihood of a recurrence; • Ensure linkages to needed psychiatric, psychological, medical, nursing, educational, and other community resources, including appropriate aftercare upon discharge (i.e., medication, outpatient appointments, etc.); and • Improve the individual child's/adolescent's ability to self-recognize and self-manage BH issues, as well as the parents'/responsible caregivers' capacity to care for their children.

[6] On November 18, 2009, the Centers for Medicare & Medicaid Services (CMS) announced that it is withdrawing the proposed rule, "Medicaid Program; Coverage for Rehabilitative Services" (72 FR 45201). As a result of this rule, Georgia (and Colorado) was asked, beginning July 1, 2007, to unbundle Medicaid services that were provided through private community-based TFC and group homes.

CATEGORY	DESCRIPTION
	MEDICAID N/A
Medical Necessity Criteria/ Program Eligibility	STATE CHILDREN'S SERVICES AGENCY Youth has a diagnosis and duration of symptoms which classify the illness as an SED (youth with an SED have a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnostic criteria and results in a functional impairment which substantially interferes with or limits the child's role or functioning in the family, school, or community activities) and/or is diagnosed with a Substance Related Disorder, and one or more of the following: • Youth has received documented services through other services such as Non-Intensive Outpatient Services and exhausted these less intensive outpatient resources. Treatment at a lower intensity has been attempted or given serious consideration, but the risk factors for out-of-home placement are compelling; the less intensive services previously provided must be documented in the clinical record (even if it via by self-report of the youth and family); or • Youth and/or family has insufficient or severely limited resources or skills necessary to cope with an immediate BH crisis; or • Youth and/or family BH issues are unmanageable in traditional outpatient treatment and require intensive, coordinated clinical and supportive intervention; or • Because of BH issues, the youth is at immediate risk of out-of-home placement; or • Because of BH issues, the youth is at immediate risk of legal system intervention or is currently involved with the Department of Juvenile Justice for behaviors/issues related to SED and/or the Substance-related disorder.
	MEDICAID N/A
License/ Certification	LICENSURE TYPES **Standard Foster Care** The Georgia Foster Parent Manual describes requirements for "*approved* foster care" providers based on meeting applicable training. "Once you are approved as a foster parent, several factors will determine when you will receive a child, including the number of children in your area who need a foster family at a given time and the age range, gender, and other characteristics of children that you have been approved to care for." **Treatment/Therapeutic Foster Care** No additional training or certification is described in the Manual specifically regarding TFC.

CATEGORY	DESCRIPTION
	However, there is a reference to Wraparound Services.[7]
Role of County/ Child Placing Agency	SAMPLE CPA CONTRACT Child Placing Agency rules expand on requirements for a child welfare agency that is any institution, society, agency, or facility, whether incorporated or not, that places children in foster homes for temporary care or in prospective adoptive homes for adoption.
Provider Qualifications and Training *(Including Notable Curriculum Details If Available)*	STATE CHILDREN'S SERVICES AGENCY **Foster Parent** Pre-Service Orientation and Information Session. A two-hour session completed in-person or via webinar. 24-hour pre-service training, IMPACT, Initial Interest, Mutual Selection, Pre-Service Training, Assessment, Continuing Development and Teamwork. During the IMPACT training, families are provided with information on numerous topics to assist prospective foster parents in understanding the Division of Family and Children's Services' role in working with birth families, the roles and responsibilities of foster and adoptive parents, and the effect of abuse and neglect on children and their families. The process also requires prospective foster and adoptive families to assess the effect this decision may have on them. The approval process is one of mutual decision making. IMPACT begins with a two-hour in-person orientation and follows with 20 training modules that last one hour each. Modules are available online. Continuing Education Annual Training Requirements — All families approved to provide foster care (including relative caregivers) must obtain a minimum of 15 hours of Continued Parent Development (CPD) each calendar year. At least five of the required hours must be obtained via in-person (one-on-one or group) interaction. CPD must be relevant to the needs of the child being placed in your home. Areas of training may include but are not

[7] Wraparound services are designed to provide immediate, critical support to placement families and the children entrusted to their care, with the intent of promoting safe and stable families and early reunification. As children enter care, the need for wraparound services will be determined through the Comprehensive Child and Family Assessment (CCFA). If a child does not yet have a CCFA, or if the need for wraparound services does not arise until after the assessment is completed, services will be provided as necessitated. Wraparound services include Crisis Intervention, In-Home Case Management, and In-Home Intensive Clinical/Therapeutic Services (Provides therapeutic and/or clinical services to the child's family in preparation for a safe return to his or her biological family and/or to maintain and stabilize a child's current placement).

CATEGORY	DESCRIPTION
	limited to: • Child safety • Parenting a developmentally disabled child • Caring for a medically fragile child • Parenting a child with ADHD • Conflict resolution • Managing specific behaviors • Understanding and implementing agency policies • Helping a child learn appropriate behaviors • Parenting the gifted child • Supporting personal growth and development • Helping a child achieve permanency and independence
	MEDICAID N/A
Evidence-Based Practices Used *(if applicable)*	Partnership Parenting is a model used by the Division of Family and Children Services (DFCS) that promotes shared parenting practices between caregivers and birth parents, allowing parents to continue with a measure of parenting while the child is in care, so that a child's parents remain closely involved in his or her life.
Required Interventions/ Program Elements	Services should include crisis intervention, intensive supporting resources management, individual and/or family counseling/training, and other rehabilitative supports to prevent the need for out-of-home placement or other more intensive/restrictive services. Services are based upon a comprehensive, individualized assessment and are directed towards the identified youth and his or her BH needs/strengths and goals as identified in the Individualized Resiliency Plan. **Service Exclusions:** • Youth with any of the following unless there is clearly documented evidence of an acute psychiatric/addiction episode overlaying the diagnosis: – Autism Spectrum Disorders including Asperger's Disorder, – Intellectual/Developmental Disabilities, – Organic Mental Disorder, or – Traumatic Brain Injury. • Youth can effectively and safely be treated at a lower intensity of service. This service may not be used in lieu of family preservation and post-adoption services for youth who do not meet the admission criteria for Intensive Family Intervention.

<table>
<tr><th>CATEGORY</th><th colspan="6">DESCRIPTION</th></tr>
<tr><td></td><td colspan="6">1 unit = 15 minutes
Initial Authorization (Maximum Length) = 90 days (288 units)
Concurrent Authorization (Maximum Length) = 90 days (288 units)
Daily Maximum Units = 48 units</td></tr>
<tr><td rowspan="3">Medicaid Delivery System</td><td colspan="3">Delivery System for SMI/SED</td><td colspan="3">Delivery System for Foster Care[8]</td></tr>
<tr><td colspan="2">☐ SED population in FFS system</td><td>☒ SED population enrolled in managed care</td><td colspan="2">☐ Foster care population in FFS system</td><td>☒ Foster care population enrolled in managed care</td></tr>
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<tr><td>Financing Sources for TFC Services</td><td>☒ IV-E</td><td>☐ Medicaid Treatment (including TCM)</td><td>☐ Medicaid Administrative</td><td>☒ State General Fund</td><td>☐ County</td><td>☒ Other[9]</td></tr>
<tr><td>Medicaid Provider of TFC Services (if applicable)</td><td>☐ State/ County Children’s Agency</td><td>☐ Child Placing Agency</td><td>☐ Foster Parent</td><td>☐ BH Services Organization/ Clinician</td><td>☐ Waiver Case Management Entity</td><td>☒ Not Applicable or Other</td></tr>
<tr><td>Payment Methods and Rates for TFC Services (if applicable)</td><td colspan="6">STATE CHILDREN’S SERVICES AGENCY
Effective July 1, 2017, the new <u>Foster Care Basic Per Diem</u> is:
• Child age birth through 5: $25.27 per day
• Child age 6 through 12: $27.26 per day
• Child age 13 and older: $29.65 per day

Unable to identify amount of TFC add-on rate (if any) paid by the state or child placing agency.</td></tr>
</table>

[8] Georgia 360 plan provides payments for basic foster care and health services for enrolled child/youth.

[9] Per a one-on-one conversation with an MCO representative during the 2018 National Academy of State Health Policy (NASHP), MCOs are conducting several pilots with child placing agencies to directly fund TFC.

CATEGORY	DESCRIPTION
	MEDICAID N/A

INDIANA: THERAPEUTIC FOSTER CARE

CATEGORY	DESCRIPTION
Service Title/ Program Name	Therapeutic Foster Care
Program Overview	STATE CHILDREN'S SERVICES AGENCY Department of Child Services (DCS) **TFC**: This option is primarily for a child 5–18 years old who scores at a "3-Therapeutic" on the Child and Adolescent Needs and Strengths (CANS) placement decision model. At this level of care, child has either a medical, developmental or behavioral/emotional need, or a high-risk behavior, that is moderate to severe. In addition to foster care in the community, the child, family and foster family are supported with treatment and support services to address and manage identified needs. *(Note: child may also have combination of any of the needs above.)* This also may be an option for a child 0–5 years old in appropriate circumstances as determined by DCS **Therapeutic Plus Foster Care**: This option is primarily for a child 5–18 years' old who scores either at the group home or residential placement on the CANS (i.e., 4–7 on the CANS placement decision model) but can be supported in a foster home with intensive services. This also may be an option for a child 0–5 years old in appropriate circumstances as determined by DCS. DCS may develop and implement pilot programs by written agreement with a CPA, relating to a foster home or group of foster homes that the CPA supervises. The pilot program may include payment amounts or procedures during a specified time period that differ from the amounts or procedures determined under the Administrative Rule for rate setting. Any payments made to a CPA will be made pursuant to a written agreement with the CPA. MEDICAID N/A
Medical Necessity Criteria/	STATE CHILDREN'S SERVICES AGENCY *See* Program Overview.

CATEGORY	DESCRIPTION
Program Eligibility	MEDICAID N/A
License/ Certification	LICENSURE TYPES Licenses are issued for a period of four years. Annual reviews are conducted by the Regional Foster Care Specialist in order to update the foster family's personal information and determine that the family continues to meet the requirements for licensure.
Role of County/ Child Placing Agency	The DCS is solely responsible for licensing all CPAs in the State of Indiana. Although CPAs can recommend foster homes for licensure, DCS is responsible for making the final decision on licensure. See Substitute Care Agreement between DCS and CPA. Also see Sample DCS contract with CPA.
Provider Qualifications and Training *(Including Notable Curriculum Details If Available)*	STATE CHILDREN'S SERVICES AGENCY **Foster Parent Training** In Indiana, foster parents must be licensed by DCS. Once a family has met all of the requirements for licensure, a standard foster family home license will be issued by DCS for foster parents to provide care for appropriately matched children in need of a foster home placement setting. This requires **10 hours of Pre-Service training**, along with First Aid, CPR, and Universal Precautions training. **Fifteen hours of in-service** training is required each year to maintain this license. DCS requires all Foster Family Home licensees to successfully complete **15 hours of in-service training annually**. The in-service training requirements will need to be completed by each licensee in the foster family household. Training also includes specialized training to meet the child's specific needs. Provider qualifications are as follows: • Must be at least 21 years of age • Passing a criminal history and background check that includes a fingerprint-based national history • Demonstrating financial stability • Own or renting own home that meets physical safety standards (e.g., fire extinguishers, adequate bedroom space, reliable transportation) • Medical statements from a physician for all household members • Successful completion of pre-service training requirements: – Don't Wait! Make the Call. Report Child Abuse and Neglect in Indiana. *Public online training and information course* – New Worker Training

CATEGORY	DESCRIPTION
	– Lodging for Training: › Foster Parent Training (Resource and Adoptive Parent Training) › Indiana Practice Model Information › DCS Legal Clerical Training – Child Protection Team Manual: › CPT Manual Part 1 › CPT Manual Part 2 › 311 Tool › CPT Manual Part 3 • Successful completion of First Aid, CPR, and Universal Precautions training. • Positive personal reference statements. • Foster parents do not need to be married. They may be single or cohabitating. A live-in relationship with a significant other or same-sex partner should be established for at least one year to demonstrate stability. • Home visits from the Regional Licensing Specialist. • Completing all required forms within the licensing packet. **DCS requires each licensee with a therapeutic certification to successfully complete 20 hours of in-service training annually, which includes 10 hours of general training and 10 hours of additional therapeutic training to meet the child's specific needs**. DCS will allow any **in-service training completed in the three-month** period prior to the end of the current training year to be counted toward the annual requirement for the next training year, if the in-service training credit is not needed to fulfill the training requirement for the current year. No more than five training hours can be carried over to the following year. Rationale for exceptions to in-service Training requirements must be maintained in an individual file at each licensing agency. Each DCS region will provide opportunities for in-service training on a regular basis. DCS will allow licensees to earn up to eight hours through alternative trainings (online trainings, books, videos, etc.). **Foster Family Responsibilities and Services:** As part of the children's system of care (SOC) and Child Mental Health Wraparound (CMHW) model used by the state, the Division of Mental Health and Addiction (DMHA) requires two and three years of experience working with children who are experiencing SED to help ensure that CMHW applicants have the knowledge and understanding related to the rewards and challenges of working with this population. The SED experience required depends on the service the

CATEGORY	DESCRIPTION
	provider will offer. The DMHA reserves the right to make the final determination of whether an applicant's SED experience meets CMHW services qualification criteria. This criteria includes, among others, providing TFC; or persons working in a capacity that may not involve mental healthcare but where the work is targeted to a defined SED population.
	MEDICAID N/A
Evidence-Based Practices Used ***(if applicable)***	**CMHW Services:** CMHW services provides youth, with SED with intensive, home- and community-based wraparound services that will be provided within an SOC philosophy and consistent with Wraparound principles. Services are intended to augment the youth's existing or recommended BH treatment plan (Medicaid Rehabilitation Option [MRO], Managed Care, etc.) and address the following: 1. The unique needs of the CMHW participant. 2. A treatment plan built upon the participant and family strengths. 3. Services and strategies that assist the participant and family in achieving more positive outcomes in their lives. CMHW services are provided by qualified, DMHA-approved, specially trained service providers who engage the participant and family in a unique assessment and treatment planning process characterized by the formation of a Child and Family Wraparound Team. The team will make available to the participant/family an array of strategies, which include, but are not limited to, the following: 1. BH and support services 2. Crisis planning and intervention 3. Parent coaching and education 4. Community resources and supports The state's purpose for providing CMHW services is to serve eligible participants, who have SED, and enable them to benefit from receiving intensive Wraparound services within their home and community with natural family/caregiver supports. The CMHW services available to the eligible participant include: 1. Wraparound Facilitation 2. Habilitation 3. Respite Care

<table>
<tr><th>CATEGORY</th><th colspan="6">DESCRIPTION</th></tr>
<tr><td></td><td colspan="6">4. Family Support and Training for the Unpaid Caregiver</td></tr>
<tr><td>Required Interventions/ Program Elements</td><td colspan="6">CANS reassessments are required every 180 days and at critical case junctures. When a reassessment is completed and the DCS determines a higher category of supervision, the rate will increase to match the new category of supervision. The effective date of the new rate will be the date of the CANS assessment. When a CANS assessment is completed at the 180-day follow-up and DCS determines a lower category of supervision, DCS will continue to pay the current rate as a stabilization rate. DCS will not lower the rate until two consecutive CANS assessments show the lower category of supervision.

Agency Responsibilities and Services: Therapeutic foster homes licensed under IC 31-27-4, including special needs and therapeutic foster homes only when the licensed child placing agency is DMHA-approved CMHW services agency provider.</td></tr>
<tr><td rowspan="3">Medicaid Delivery System[10]</td><td colspan="3">Delivery System for SMI/SED</td><td colspan="3">Delivery System for Foster Care</td></tr>
<tr><td colspan="2">☐ SED population in FFS system</td><td>☒ SED population enrolled in managed care</td><td colspan="2">☐ Foster care population in FFS system</td><td>☒ Foster care population enrolled in managed care</td></tr>
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<tr><td>Payment Methods and Rates for TFC</td><td colspan="6">STATE CHILDREN’S SERVICES AGENCY

Pursuant to the CPA rate rule, behavioral health services are unbundled from the maintenance and administrative payment to the CPA so that actual costs are</td></tr>
</table>

[10] For FFS children/youth, MRO services may be billed on the same claim with other IHCP-covered services; for managed care children/youth, MRO services must be billed separately and submitted to the IHCP **FFS claim-processing** unit rather than to the child/youth’s managed care entity (MCE). Also see Managed Care in Indiana and the Indiana Medicaid Managed Care Quality Strategy Plan 2018.

CATEGORY	DESCRIPTION
Services *(if applicable)*	**identifiable and alternative funding sources can be accessed to enable the most efficient use of state funds to pay for child services**. As such, DCS will refer separately for BH services to CPAs or other BH providers who are able to bill Medicaid and who have a contract with DCS. The referral given at the time of placement authorizes the provider to provide the service. Providers do not have to wait until Medicaid approves units to start performing the services. If the child is not Medicaid eligible or Medicaid denies the approved service, then DCS will pay based on the initial referral. CPAs can collaborate with other providers to provide Medicaid services with reference to BH services. Effective January 1, 2012, for children who are Medicaid eligible, BH costs shall be billed to Medicaid for services authorized by DCS that are Medicaid eligible. For services that are not covered by Medicaid but are authorized by DCS, DCS will pay through a contract with the provider. When DCS makes a referral for BH services, the referred counseling units will include both Medicaid billable units and DCS billable units. DCS will only pay for counseling sessions that are denied by Medicaid. The referred units should not be interpreted to limit the amount of units billed to Medicaid, but serve as a cap as to what can be billed to DCS. DCS will also refer units, for billing to DCS without first billing Medicaid, for when the therapist is requested by DCS to write court reports and attend child and family team meetings and court.

PAYMENTS BY CPA[11]	INFANT–4 YEARS	5–13 YEARS	14–18 YEARS
Foster Care (maintenance)	$ 19.49	$ 21.17	$ 24.42
Foster Care with services	$ 27.26	$ 28.94	$ 32.19
Therapeutic Foster Care	$ 39.40	$ 41.08	$ 44.33
Therapeutic Plus	$ 63.15	$ 64.83	$ 68.08

The CPA is required to first bill Medicaid for the Medicaid eligible referred services and request Prior Authorization (PA). If the initial 20 Medicaid units are used and PA is denied, the provider can bill DCS if the number of units on the referral has not been maximized by Medicaid billings. The number of units listed on the referral will last the length of the

[11] Each CPA is required to pay its foster parents at least the amount set forth above. If a CPA chooses to pay its foster parents at a higher rate it may do so, but those costs cannot be passed on to DCF. DCF will set CPA rates on a calendar year basis. At the beginning of each calendar year, DCF will have a public comment period and a public hearing to discuss the rate setting methodology for that year. The public comment period and the public hearing will be held prior to cost report training.

CATEGORY	DESCRIPTION
	ICPR19. *Note: If a PA is initially denied and later there are changed circumstances involving the child that would necessitate medically necessary BH (e.g., a critical case juncture), the CPA is expected to request another PA from Medicaid. If the child is not Medicaid eligible and if private insurance is not available or does not cover the costs of services or treatment, BH costs that are referred by DCS shall be billed to DCS through a contract with DCS.* Probation youth will be paid the rate corresponding to that of the therapeutic category of supervision until there is a probation approved assessment tool. The only exception is if the Probation youth is seen by a Community Mental Health Center which conducts CANS.
	MEDICAID Not applicable; CPA or other BH providers bill Medicaid for covered BH, not TFC, services provided to children in foster care.

MASSACHUSETTS: INTENSIVE FOSTER CARE

CATEGORY	DESCRIPTION
Service Title/ Program Name	Intensive Foster Care (IFC)
Program Overview	STATE CHILDREN'S SERVICES AGENCY Department of Children and Families (DCF) **IFC:** Programs that provide therapeutic services and supports in a family-based placement setting to children and youth, from birth through 22 years of age, for whom a traditional foster care environment is not sufficiently supportive; who are transitioning from a residential/group home level of care and require the intensity of services available through this program; or who are discharging from a hospital setting. Referred children and youth come from diverse cultural, linguistic, religious, ethnic, or racial backgrounds and have varying sexual or gender orientations. They may have a range of behavioral, cognitive, and mental health strengths and needs. With the appropriate program strengths, safety planning, and supports, this range for IFC could include children with fire-setting, sexual offending and sexual reactive behaviors, or various medical needs. Ideally, and when appropriate, children remain in their communities, attend their school of origin, maintain their social network, and continue contact with their families. Some are teenage mothers who need support and guidance with their parenting skills. Other models of IFC (i.e., IFC Other Models) that represent an array of service requirements and program designs may be specified by each purchasing governmental unit to meet the unique challenges that face

CATEGORY	DESCRIPTION
	a specialized population of foster care children and youth. **IFC Other Models:** Service models designed to meet the unique challenges that face a specialized population of foster care children and youth. These models represent an array of service requirements and program designs specified by the purchasing governmental unit. **IFC Level One Homes:** Licensed foster homes with expertise sufficient to meet the needs of children and youth referred for non-specialized IFC. **IFC Level Two Homes:** Licensed foster homes with expertise compatible with IFC Level One where caregivers have additional applicable training and extensive previous foster home experience. A **stipend** is paid to the caregiver for providing personal care services to an eligible child/youth residing either in the caregiver's home or in the child/youth's own home. An **operational service rate** is paid separately from caregiver stipends and reflects the portion of the complete IFC services specified by the purchaser, including, but not limited to, therapeutic services contributing to successful placement for a child/youth. A **teen parent rate** is available for the placement of a teen and the teen's child in an IFC home. The payment of the teen parent IFC rate is made only when both the teen and the teen's child are in the care or custody of DCF.
	MEDICAID N/A
Medical Necessity Criteria/ Program Eligibility	STATE CHILDREN'S SERVICES AGENCY *See* Program Overview and Evidence-Based Practices Used
	MEDICAID N/A
License/ Certification	STANDARD FOSTER CARE All families with whom DCF places children must be licensed, including those that are utilized on a temporary, short-term basis such as respite homes and visiting resources. Respite homes are licensed foster/pre-adoptive families who accept short-term, temporary placements of children in order to provide a break to the foster/pre-adoptive family with whom the child normally resides. Visiting resources are licensed foster/pre-adoptive

CATEGORY	DESCRIPTION
	families with whom children are placed on a short-term basis such as during the vacation period of a community residential program. **Licensing Study:** The participation of each applicant in the completion of a comprehensive family assessment, the purpose of which is to determine that the family meets Department standards for licensing as a Department of Social Services (DSS) foster/pre-adoptive family. Length of time a license is valid before renewal is required, is two years. TREATMENT/THERAPEUTIC FOSTER CARE Requires licensure as a standard foster home plus additional applicable training and extensive previous foster home experience based on the level of care required by the child.
Role of County/ Child Placing Agency	Foster care agencies are licensed placement agencies responsible for recruitment and approval of foster parents/homes to care for children in need of alternative placement. Under an agreement with the Executive Office of Health and Human Services, Early Education and Care, licenses foster care placement in Massachusetts. Placement agency is defined as "a department, agency, or institution of the Commonwealth, or any political subdivision thereof, or any organization incorporated under M.G.L. c. 180, one of whose principal purposes is providing custodial care and social services to children, which receives by agreement with a parent or guardian, by contract with a state agency or as a result of referral by a court of competent jurisdiction, any child under 18 years of age, for placement in family foster care or in a residential program, or for adoption." *See* Placement Agency Regulations for additional description of roles and functions.
Provider Qualifications and Training *(Including Notable Curriculum Details If Available)*	STATE CHILDREN'S SERVICES AGENCY **Foster Parent Training** After applying to become an adoptive or foster parent, individuals must complete a Massachusetts Approach to Partnership in Parenting (MAPP) training course. MAPP training is required for all persons seeking to provide foster care or adopt a child in Massachusetts. MAPP training is broken down into 3-hour classes occurring once or twice a week for several weeks, for a total of 30 hours of training. Some six hour sessions are held on weekends. Topics discussed in the MAPP program include: communication, positive discipline, child guidance and building self-esteem.

CATEGORY	DESCRIPTION
	Intensive Foster Care Training IFC parents receive MAPP training and participate in the home study process to ready their home for the placement of a child. MAPP training is broken down into three-hour classes occurring once or twice a week for several weeks, for a total of 30 hours of training. MAPP Training is offered both by the DCF and contracted adoption agencies. Topics discussed in the MAPP program include: communication, positive discipline, child guidance and building self-esteem. After MAPP training, a social worker from MAPP will visit the home of the prospective foster family, check personal references, and write a license study that describes the family and any characteristics that might make a child an especially good fit for the home, including personality, background, and emotional or physical needs.
	MEDICAID N/A
Evidence-Based Practices Used ***(if applicable)***	**Child Home-Based Rehabilitation:** An IFC Other Model that provides IFC placement, and specialized IFC services for children with problem sexualized behavior and sexually abusive youth. In addition to placement in specially trained, IFC homes, youth receive intensive case management, clinical, psychiatric, psychopharmacological, health care, educational, and recreational services supported by 24-hour-a-day, seven-day-a-week emergency coverage. **Emergency Shelter Homes:** An IFC Other Model that provides IFC placement for children from birth through 22 years of age for duration not to exceed 45 days. IFC emergency foster care providers are responsible for facilitating emergency health care, emergency school placement, intensive family work to support reunification and collaboration with community providers that have pre-existing relationships with youth placed. **Multiple Acute A:** An IFC Other Model consisting of TFC providing placement services that meet a combination of substantial medical, psychiatric, and cognitive needs of youth and their families. The placement population is more challenging than the children typically placed into IFC. It provides placement supports and family services that are specially designed to meet the complex challenges of children who have been abused and neglected and present with cognitive and physical impairments. Children and youth may also exhibit one or both of the following: a range of behavioral or emotional needs; or a wide range of disabilities including developmental disabilities, psychiatric disorders, chronic

CATEGORY	DESCRIPTION
	illnesses and severe physical impairments. **Multiple Acute B:** An IFC Other Model consisting of TFC providing placement services that meet a combination of substantial medical, psychiatric, and cognitive needs of youth and their families. The placement population is more challenging than the children and youth typically placed into IFC. It provides placement supports and family services that are specially designed to meet the complex challenges of children and youth who have been abused and neglected and present with cognitive and physical impairments. These children and youth may also exhibit one or both of the following: a range of behavioral or emotional needs; or a wide range of disabilities including developmental disabilities, psychiatric disorders, chronic illnesses and severe physical impairments. Additionally, it provides transportation and housing for children needing wheelchair accessibility. **Sexually Exploited Youth Services:** An IFC Other Model consisting of placement services provided for the child welfare service needs of sexually exploited children including, but not limited to, services for sexually exploited children residing in the Commonwealth at the time they are taken into custody by law enforcement or who are identified by DCF as sexually exploited children. These services are provided for the duration of any legal or administrative proceeding in which they are either the complaining witness, the defendant or the subject child. This includes appropriate services provided to a child reasonably believed to be a sexually exploited child in order to safeguard the child's welfare. **Transitions to Adulthood Services:** An IFC Other Model that provides IFC foster care services to young adults 18–22 years of age, assisting them in transitioning to adulthood, in order to assist the participants to develop lifelong family connections while gaining skills to lead self-sufficient, healthy, productive and responsible adult lives. The program uses a Positive Youth Development Approach that focuses on safety, relationship building, youth participation, skill building, and community involvement and a team approach that includes the participant, the caregiver and community professionals. **Transitions to Adult Services:** An IFC Other Model involving IFC and the intensive support services package for children, youth, and adolescents leaving residential schools who have special cognitive, language and behavioral needs. These individuals may have received diagnoses such as severe learning disabilities or developmental disabilities. This program seeks to find foster families who are committed to providing permanent homes that will eventually be funded under adult foster care, and who are able to implement highly technical behavioral treatment plans and use augmentative communication strategies in

<table>
<tr><th>CATEGORY</th><th colspan="6">DESCRIPTION</th></tr>
<tr><td></td><td colspan="6">order to achieve safety and stability within the community.</td></tr>
<tr><td>Required Interventions/ Program Elements</td><td colspan="6">See Program Overview and Evidence-Based Practices Used</td></tr>
<tr><td rowspan="3">Medicaid Delivery System[12]</td><td colspan="3">Delivery System for SMI/SED</td><td colspan="3">Delivery System for Foster Care</td></tr>
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The approved rate includes payment for all care and services that are part of the program of services of an eligible provider, as explicitly set forth in the terms of the purchase agreement between the eligible provider and the purchasing governmental unit or units. Each eligible provider must, as a condition of acceptance of payment made by any purchasing governmental units for services rendered, accept the approved program rate as full payment and discharge of all obligations for the services rendered. Payment from any other source is used to offset the amount of the purchasing governmental unit's obligation for services rendered to the publicly assisted child/youth.</td></tr>
</table>

[12] Mandatory Medicaid managed care enrollment for most populations through MassHealth Managed Care and MassHealth BH/SUD PIHP except for children in foster care or receiving adoption assistance (whose enrollment is voluntary). Children/youth who are clients of DCF or Department of Youth Services who do not choose to enroll in Managed Care may instead choose to receive medical services through FFS, but are nonetheless required to enroll with the BH contractor for BH services.

CATEGORY	DESCRIPTION

SERVICE	OPERATIONAL	STIPEND	TOTAL	UNIT
Intensive Foster Care				
Intensive Foster Care One	$ 59.22	$ 58.45	$ 117.67	Per Placement/Day
Intensive Foster Care Two	$ 59.22	$ 68.91	$ 129.70	Per Placement/Day
Teen Parent	$ 66.87	$ 83.30	$ 150.17	Per Placement/Day
Enhanced Intensive Foster Care	$ 104.86	$ 89.83	$ 194.68	Per Placement/Day

SERVICE	OPERATIONAL	STIPEND	TOTAL	UNIT
Intensive Foster Care Specialty				
Transitions to Adulthood	$ 78.14	$ 66.82	$ 144.95	Per Placement/Day
Emergency Shelter Homes	$ 71.92	$ 77.28	$ 149.20	Per Placement/Day
Child Home-Based Rehabilitation	$ 72.72	$ 79.37	$ 152.09	Per Placement/Day
Transitions to Adult Services	$ 138.68	$ 59.79	$ 198.46	Per Placement/Day
Multiple Acute Level A	$ 115.62	$ 106.45	$ 222.07	Per Placement/Day
Multiple Acute Level B	$ 197.12	$ 106.45	$ 303.57	Per Placement/Day
Sexually Exploited Youth	$ 118.50	$ 110.75	$ 229.24	Per Placement/Day

Also see 101 CMR 411.00: Rates For Certain Placement, Support, And Shared Living Services for additional details about rates and placement levels.

MEDICAID

N/A

MISSOURI: THERAPEUTIC FOSTER CARE

CATEGORY	DESCRIPTION

CATEGORY	DESCRIPTION
Service Title/ Program Name	Therapeutic Foster Care
Program Overview	STATE CHILDREN'S SERVICES AGENCY Children referred to the program shall be between the ages of 6–21 and demonstrate behavior which indicates the need for intensive and individualized intervention. Children referred to this program require a higher level of care than traditional or elevated needs foster home, but may not require placement in a restrictive setting. Children accepted into the TFC program have severe behavioral disorders, psychiatric diagnoses, delinquency and symptoms of complex trauma. TFC exists to serve children and youth whose special needs are severe enough that in the absence of such programs, they would be at risk of placement into restrictive residential settings such as hospitals, psychiatric centers, correctional facilities or residential treatment programs. This program may also be used for children who have received residential treatment services but are no longer in need of such services. To refer a child to the program, the case manager must submit a completed referral packet to the appropriate Residential Care Screening Team Coordinator (RCST). The case manager must assess the child's need, via completion of the Residential Treatment Referral (CS-9), for TFC. The state agency shall seek a less restrictive setting once the child's presenting problems have been replaced with appropriate coping behaviors. At the end of six months, the transitional plan must be initiated. To prepare for the transition, a review shall be conducted by the contractor and RCST at the end of five months to ensure a successful transition. If additional time in the program is requested, the contractor shall seek authorization from the RCST and shall provide justification for keeping the child in the program including what will be accomplished with additional time. After the child is discharged from the program, the contractor shall provide 30 days of transition planning which includes providing mentoring/support to the step down resource. MEDICAID Unable to determine extent of Medicaid payment or coverage policy for TFC through online materials.
Medical Necessity Criteria/ Program Eligibility	STATE CHILDREN'S SERVICES AGENCY *See* Program Overview. MEDICAID Unable to determine extent of Medicaid payment or coverage policy for TFC through online

CATEGORY	DESCRIPTION
	materials.
License/ Certification	LICENSURE TYPES **Standard Foster Care**[13] **Pre-service Training:** Prior to licensure, each adult with parenting responsibilities is required to successfully complete a competency based training approved by the Children's Division (CD). **In-service Training:** To maintain a foster home license each foster parent shall meet performance-based criteria as part of a professional family development plan and complete a prescribed number of foster parent training hours as approved by the licensing authority during each **two-year licensure period**. The subject of training shall be directly tied to the foster parent professional development plan and related to the needs and ages of children in their care. The maximum capacity of homes providing care for youth with elevated needs as defined in 13 CSR 35-60.070 and youth with elevated medical needs as defined in 13 CSR 35-60.100 shall not exceed four placements with no more than two placements of youth with elevated needs. The children of the foster parent are counted within the maximum until they reach the age of 18. **Treatment/Therapeutic Foster Care** No additional rules pertaining to TFC were identified. However, rules did describe, "**Medical foster care** — A licensed foster home utilized to meet the needs of a child with extraordinary medical needs. Medical foster parents shall have a foster parent license and receive training from qualified medical care providers specific to the unique medical needs of the child." Characteristics of children in need of medical foster care are described as having a diagnosed medical or **mental health condition** that requires 24-hour availability of a resource provider specifically trained to meet the elevated medical needs in order to successfully function in a foster family home setting and does not require placement in an institutional setting such as residential care or a hospital. Medical resource provider requirements for placement of youth with elevated medical

[13] See Rules of DSS Division 35 — Children's Division Chapter 60 — Licensing of Foster Family Homes at: https://www.sos.mo.gov/cmsimages/adrules/csr/current/13csr/13c35-60.pdf.

CATEGORY	DESCRIPTION
	needs. In order to qualify to receive the medical maintenance rate from the division, the resource provider shall: • Be a licensed foster parent; • Enter into a contract with the CD to provide medical foster care; • Successfully complete and provide documentation of the completion of individualized medical training specific to the needs of the youth provided by the youth's health care provider or other provider and approved by the division; and • Be currently providing placement for a youth who meets the criteria of a youth with elevated medical needs.
Role of County/ Child Placing Agency	Requirements for Licensed Child Placing Agencies.
Provider Qualifications and Training *(Including Notable Curriculum Details If Available)*	STATE CHILDREN'S SERVICES AGENCY **Foster Parent Training** The CD operates a specialized foster care program for children who are behaviorally or emotionally disturbed or in need of extensive medical care. These children are placed with licensed foster parents who have received **special training** and who also receive a subsidy to cover the costs of room, board, and necessary treatment. The **TFC parents are trained and supported to implement key elements of treatment** in the context of the family and community life while promoting the goals of permanency planning for youth in their care. Vendor/Facility requirements of TFC: CD licensed; contract/adoption subsidy agreement; facility in which a child may be placed; open as a vendor in Family and Children's Electronic System.
	MEDICAID Unable to determine extent of Medicaid payment or coverage policy for TFC through online materials.
Evidence-Based Practices Used *(if applicable)*	No evidence-based TFC model was identified through review of online materials.
Required Interventions/ Program Elements	**Agency Responsibilities and Services:** Each therapeutic foster home and child is assigned a TFC worker with the primary responsibility for the development of treatment plans. The TFC worker also provides support and consultation to the TFC foster parents, to families of children in care, to children enrolled in the TFC program, and to other treatment team members. The TFC worker coordinates activities to ensure children and families

<table>
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<tr><td></td><td colspan="6">receive needed services according to their treatment plan. The contractor provides at least weekly consultation to the TFC home and in-person contact every two weeks or more frequently when indicated.

Foster Family Responsibilities and Services: Because treatment is individualized, each child, youth, and family receives flexible services over time to meet their changing needs. Treatment typically involves teaching adaptive, pro-social skills and responses that equip young people and their families with the means to deal effectively with the unique conditions or individual circumstances that have created the need for treatment. The term “individualized treatment” presumes stated, measurable goals based on a professional assessment, a set of written procedures for achieving those goals and a process for assessing the results. Treatment accountability requires that goals and objectives be time limited and outcomes systematically monitored.</td></tr>
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<tr><td>Financing Sources for TFC Services</td><td>☒I V-E</td><td>☐ Medicaid Treatment</td><td>☐ Medicaid Administrative</td><td>☒ State General Fund</td><td>☐ County</td><td>☐ Other</td></tr>
</table>

14 The Missouri (MO) HealthNet Managed Care population does include children in the care and custody of the DSS in Group COA 4 (Children in Care and Custody and Adoption Subsidy), ME Codes 7 (Foster Care – IV E). Services provided by a Community Psychiatric Rehabilitation provider shall be reimbursed by the state agency on a FFS basis according to the terms and conditions of the MO HealthNet program. BH Services for Category of Aid (COA) 4 Children: For children within the COA 4 group, the **health plan shall not be financially responsible for** Comprehensive Community Support Services. Comprehensive Community Support Services are provided to children in the custody of the CD who are found to have behavioral conditions which require rehabilitative services at a residential treatment or **specialized foster care level of care** or who are being discharged from these two treatment levels, and who require comprehensive community support services in order to maintain the rehabilitation treatment outcome in a less restrictive environment. The CD identifies children in the custody of the CD qualifying for these services and authorizes provision of comprehensive community support. Comprehensive community support services include any medical or remedial service reasonable and necessary for maximum reduction of a behavioral disability and restoration of the child to his or her best possible functional level.

<table>
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<tr><td></td><td></td><td>(including TCM)</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Medicaid Provider of TFC Services (if applicable)[15]</td><td>☐ State/ County Children's Agency</td><td>☐ Child Placing Agency</td><td>☐ Foster Parent</td><td>☐ BH Services Organization/ Clinician</td><td>☐ Waiver Case Management Entity</td><td>☒ Not Applicable or Other</td></tr>
<tr><td>Payment Methods and Rates for TFC Services (if applicable)</td><td colspan="6">
STATE CHILDREN'S SERVICES AGENCY
Standard Payment Rate for Foster Family Alternative Care
<table>
<tr><th>TYPE OF EXPENDITURE</th><th>AGE LIMITATION</th><th>AMOUNT PAYABLE</th></tr>
<tr><td>Maintenance</td><td>0–5 years
6–12 years
13 and over</td><td>$ 300.00
$ 356.00
$ 396.00</td></tr>
<tr><td>Youth with Elevated Needs-Level A/Medical Foster Care</td><td>All ages</td><td>$ 777.00</td></tr>
<tr><td>Youth with Elevated Needs-Level B Foster Care</td><td>All ages</td><td>$ 1,549.00</td></tr>
</table>
Therapeutic Foster Care
For all TFC placements, the maintenance should always be set to No Maintenance Payment. This service will be paid utilizing the service authorization screen and the service code TFCM. The Intake Admission Assessment, Evaluation and Rehabilitative Treatment Plan continue to be a requirement of the residential treatment contract.

Payment/Service Categories for TFC: Medicaid allowed; maintenance allowed; special expense allowed; residential treatment services allowed.

MEDICAID
Unable to determine extent of Medicaid payment or coverage policy for TFC through online materials.
</td></tr>
</table>

[15] Unable to determine extent of Medicaid payment or coverage policy for TFC through online materials.

NEW YORK: TREATMENT FOSTER CARE

CATEGORY	DESCRIPTION
Service Title/ Program Name	Treatment Foster Care[16]
Program Overview	STATE CHILDREN'S SERVICES AGENCY TFC in New York is a state supervised (New York State Office of Children and Family Service [OCFS]) and locally administered service, which mirrors the state's decentralized child welfare structure. The TFC program is designed to service children/youth up to age 21 (with a minimum IQ of 65) who have moderate to severe behavioral issues and emotional conditions and can be supported within a family setting. The children will be placed in a family setting for a short term (average 12-months) based on the severity of their emotional or behavioral condition. Foster parents will be recruited, trained and supported to become part of the Treatment Team. The foster parents will receive pre-service training, participate in group support meetings, and have access to program staff back-up and support 24-hours a day/ 7 days a week. The foster parents will be contacted regularly by telephone to relay information about the child's behavior and to discuss implementation of the treatment plan. TFC homes require one to two case management visits per week and four contacts per month, which may include telephone calls, compared with one visit per month in traditional foster care and two visits per month in special board rate homes.
	MEDICAID N/A
Medical Necessity Criteria/ Program Eligibility	STATE CHILDREN'S SERVICES AGENCY TFC eligibility does not require a specific mental health diagnosis. In New York City, the Administration for Children's Services (ACS); guidelines require that an ACS-facilitated Placement Presentation Family Team Conference determine eligibility for TFC.
	MEDICAID N/A

[16] The majority of information about New York was obtained from an April 2018 report, State Practices in Treatment/Therapeutic Foster Care, prepared for the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

CATEGORY	DESCRIPTION
License/ Certification	LICENSURE TYPES **Standard Foster Care** Foster homes are "certified" (the term used for non-relative homes) or "approved" (the term used for relatives) by OCFS according to the same standards. Local agencies provide training on techniques and managing behavior and preventing abuse and neglect, and understand the expectations of the agency. Foster parents are certified/approved when the following are completed: a home study; State Central Register of Child Abuse and Maltreatment clearance; criminal history record review process, including fingerprinting. **Treatment/Therapeutic Foster Care** In some agencies and local departments of social services, Therapeutic Foster Boarding Homes are foster homes approved to provide intensive care to certain behaviorally disordered or emotionally disturbed foster children eligible for exceptional care who would otherwise require a higher level of care. TFC foster parents receive enhanced services from a foster care agency and specialized, ongoing training.
Role of County/ Child Placing Agency	The state contracts with county child welfare systems that in turn contract with local agencies to recruit and train TFC parents. See example of a county contract for foster care services.
Provider Qualifications and Training *(Including Notable Curriculum Details If Available)*	STATE CHILDREN'S SERVICES AGENCY **Foster Parent Training** Many counties and agencies use the MAPP/Group Preparation and Selection Pre-Certification Training Program. Although it is not required by the OCFS, it is the recommended selection and preparation program. The MAPP approach to foster parenting encourages open communication and trust among foster families, adoptive families, birth families and casework staff. The MAPP program examines 12 criteria or skills necessary for successful foster/adoptive parenting. Through role-playing, personal profiles, and other techniques, the home finder and the applicant make mutual decisions about foster parenting. **Treatment Foster Care** ACS requires training in the Problem Solving Therapy–Primary Care (PST-PC) BH model for all TFC parents. PST-PC is a therapy approach used to treat depression and anxiety in a primary care environment. The approach is composed of six to ten 30-minute sessions to help patients solve the "here and now" problems contributing to their mental health concerns. TFC parents must complete a 30-hour MAPP training program and 12–15 additional hours of training

CATEGORY	DESCRIPTION
	annually. The ACS program description does not differentiate between traditional foster parents and TFC parents in their training requirements.
	MEDICAID N/A
Evidence-Based Practices Used *(if applicable)*	Although provider agencies may choose their own model of TFC, the service is characterized by access to behavioral and medical health supports, along with more-intensive case management services than are required in traditional foster care. One provider agency in Erie County described their plans to expand TFC services using the Mockingbird Family Model (MFM), which is a foster care service delivery model designed to improve the safety, well-being, and permanency of children, adolescents, and families in foster care. MFM is grounded in the assumption that families with access to resources and support networks are best equipped to provide a stable, loving, and culturally supportive environment for children.[17] Another agency in Erie County described using the Coached Visitation Model, which is based on the research and publications of Marty Beyer and was originally promoted by New York City's ACS.[18]
Required Interventions/ Program Elements	Interventions vary based on the unique needs of each child.

[17] The model revolves around the concept of the MFM Constellation, which intentionally establishes a sense of extended family and community. In each constellation, 6–10 families (foster, kinship, foster-to-adopt, and/or birth families) live near a central licensed foster or respite care family (Hub Home), whose role is to provide support. The support provided through the Hub Home includes assistance in navigating systems, peer support for children and parents, impromptu and regularly scheduled social activities, planned respite nearly 24/7, and crisis respite as needed.

[18] Visit Coaching helps families learn how their child's behavior is shaped by the adult's words, actions, and attitudes. Families are coached to improve the fit between their limit-setting and the child's temperament and behavior. Visit Coaching is fundamentally different from supervised visits because of the focus on the strengths of the family and the needs of the children. Visit Coaching supports families to make each visit fun for their children and to meet the unique needs of each child.

CATEGORY	DESCRIPTION					
Medicaid Delivery System[19]	**Delivery System for SMI/SED**[20]			**Delivery System for Foster Care**[21]		
	☐ SED population in FFS system	☒ SED population enrolled in managed care		☐ Foster care population in FFS system	☒ Foster care population enrolled in managed care	
	☐ BH benefit managed FFS	☒ BH benefit managed by MCO or PIHP		☐ BH benefit for children in foster care managed FFS	☒ BH benefit for children in foster care managed by MCO or PIHP	
Financing Sources for TFC Services	☒ IV-E	☒ Medicaid Treatment (including TCM)	☐ Medicaid Administrative	☒ State General Fund	☒ County	☐ Other
Medicaid Provider of TFC Services *(if applicable)*	☐ State/ County Children's Agency	☒ Child Placing Agency	☒ Foster Parent	☐ BH Services Organization/ Clinician	☐ Waiver Case Management Entity	☐ Not Applicable or Other

[19] The state submitted an amendment to its current 1115 New York Medicaid Redesign Team Waiver (Demonstration) to create a children's model of care that enables qualified MCOs in Mainstream Medicaid Managed Care (MMMC) and HIV Special Needs Plans (SNPs) throughout the state to comprehensively meet the needs of children and youth under 21 years of age with BH and Home- and Community-Based Services (HCBS) needs, specifically, medically fragile children, children with BH diagnosis and children in foster care with developmental disabilities. On January 1, 2019, this amendment requests authority to: provide Health Home care management for children eligible for HCBS under this 1115 Demonstration; Transition the six children's Section 1915(c) HCBS waivers to the 1115 Demonstration authority; **Incorporate Medicaid State Plan behavioral health services into the MMMC and HIV SNP contracts for enrolled children with an implementation date of July 1, 2019**; Include children placed in a Voluntary Foster Care Agency in MMMC or HIV SNPs no earlier than July 1, 2019; Offer an HCBS benefit package identical to the 1115 HCBS package to children at-risk of institutionalization but not meeting institutional level of care functional criteria. The children must meet targeting criteria of BH or having experienced abuse, neglect and maltreatment or meeting Health Home complex trauma targeting criteria, risk factors and having functional needs at-risk of institutional care under the Demonstration; and Transition HCBS to risk-based reimbursement no earlier than January 1, 2021.

[20] The state's 1115 waiver will incorporate Medicaid State Plan BH services into the MMMC and HIV SNP contracts for enrolled children with an implementation date of July 1, 2019.

[21]The state's proposed 1115I waiver will include children placed in a Voluntary Foster Care Agency (VFCA) in MMMC or HIV SNPs no earlier than July 1, 2019.

CATEGORY	DESCRIPTION
Payment Methods and Rates for TFC Services *(if applicable)*	STATE CHILDREN'S SERVICES AGENCY The State of New York funds foster care programs through a combination of state general funds, title IV-E foster care funding, and Medicaid dollars. TFC is included in the foster care funding mechanisms; there is no designated funding for TFC. The state establishes maximum state aid rates (MSARs) for agencies and foster parent stipends, which serve as the upper limit on what the county can reimburse. There is no minimum rate, however, and counties are allowed to set their own rates as long as they do not exceed the MSAR. Rates are calculated separately for board and care stipends for foster parents and administrative payments for foster care agencies. Foster parent stipends specify three tiers of MSARs — regular, special, and exceptional; TFC typically falls under the exceptional rate. Local commissioners develop lists of eligibility conditions that may be covered by the special and exceptional rates, which are uniform across regions in New York. For foster care agencies, the state determines a unique rate per provider agency based on the previous year's spending within state established parameters. Financing is administered at the county level, and counties have the discretion to develop their own funding strategies. In Erie County, the Children's Services (CS) Division oversees and distributes funding to provider agencies. MEDICAID Medicaid funding supports therapeutic services for children. New York plans to transition all foster children into its managed care model, which currently serves only a small percentage of children in foster homes directly managed by the child welfare agency. The state is also exploring how to bring current TFC services that are non-encounter-based, such as social work services and nursing services, into managed care.

OREGON: THERAPEUTIC FOSTER CARE

CATEGORY	DESCRIPTION
Service Title/ Program Name	Therapeutic Foster Care[22]
Program Overview	**STATE CHILDREN'S SERVICES AGENCY** TFC is a clinical intervention, which includes placement in specially trained foster parent homes, for foster children with severe mental, emotional or BH needs.
	MEDICAID The State of Oregon established the Behavior Rehabilitation Services (BRS) Program to remediate the BRS child/youth's debilitating psychosocial, emotional and behavioral disorders by providing such services as behavioral intervention, counseling, and skills-training. State administrative rules describe the general program requirements for the BRS program, PA process, services and placement related activities, BRS contractor and BRS provider requirements, reimbursement rates, and compliance and oversight activities. TFC model means services and placement related activities are provided to the BRS child/youth who resides in the home of an approved provider parent. TFC Model: The BRS contractor must ensure that its BRS program, either operated by itself or by its BRS provider, meets and maintains the following adult to child ratios in its TFC homes: • Shelter Evaluation and Assessment and Independent Living Services: – A maximum of three BRS child/youth shall be placed in the home of an approved provider parent; – A maximum of five children (including both BRS child/youth and non-BRS child/youth) and young adults (BRS child/youth only) shall live in an approved provider parent home with two parents;

[22] Oregon's most vulnerable children are being placed into a foster care system that has serious problems. Child welfare workers are burning out and consistently leaving the system in high numbers. The supply of suitable foster homes and residential facilities is dwindling, resulting in some children spending days and weeks in hotels. Foster parents are struggling with limited training, support and resources. Agency management's response to these problems has been slow, indecisive and inadequate. DHS and child welfare managers have not strategically addressed caseworker understaffing, recruitment and retention of foster homes, and a poorly implemented computer system that leaves caseworkers with inadequate information. *See* Foster Care in Oregon: Chronic Management Failures and High Caseloads Jeopardize The Safety Of Some of the State's Most Vulnerable Children, Child Welfare System, Oregon Department of Human Services, Report 2018 – 05.

CATEGORY	DESCRIPTION
	– A maximum of four children (including both BRS child/youth and non-BRS child/youth) and young adults (BRS child/youth only) shall live in an approved provider parent home with one parent; and – No more than two children (including both BRS child/youth and non-BRS child/youth) under the age of three shall live in an approved provider parent home. • Intensive Community Care, TFC and Enhanced TFC: – A maximum of two BRS child/youth shall be placed in the home of an approved provider parent; – A maximum of five children (including both BRS child/youth and non-BRS child/youth) and young adults (BRS child/youth only) shall live in an approved provider parent home with two parents; – A maximum of four children (including both BRS child/youth and non-BRS child/youth) and young adults (BRS child/youth only) shall live in an approved provider parent home with one parent; and – No more than two children (including both BRS child/youth and non-BRS child/youth) under the age of three shall live in an approved provider parent home. Notwithstanding section (8)(b)(A)(i) and (ii) of this rule, the BRS contractor or BRS provider may exceed these limits on the maximum number of children and young adults who shall live in a home when the approved provider parent is providing respite care. The BRS contractor must ensure that its BRS program, either operated by itself or by its BRS provider, meets and maintains the adult to child or young adult ratios described in Oregon Youth Authority (OYA)-specific BRS program rules for TFC homes.
Medical Necessity Criteria/ Program Eligibility	STATE CHILDREN'S SERVICES AGENCY N/A MEDICAID BRS's are provided to children/youth **to remediate debilitating psycho-social, emotional and behavioral disorders**. To provide early intervention, stabilization and development of appropriate coping skills upon the recommendation of a licensed practitioner of the healing arts within the scope of their practice within the law. Prior approval is required. The population serviced will be Early and Periodic Screening, Diagnostic and Treatment (EPSDT) eligible children/youth who have **primary mental, emotional and behavioral disorders and/or developmental disabilities that prevent them from functioning at developmentally appropriate levels in their home, school or community**. They exhibit such symptoms as drug and alcohol abuse, anti-social behaviors that require close supervision and intervention and structure, sexual behavior problems, victims of severe family conflict, behavioral disturbances often resulting from psychiatric disorders of the

CATEGORY	DESCRIPTION
	parents, medically compromised and developmentally disabled children/youth who are not otherwise served by the State Mental Health Developmental Disability Services Division. Checklist for Referrals: • Multidisciplinary team met to discuss need (list required people). • Multidisciplinary team reviewed CANS or Risk Needs Assessment (RNA). • Multidisciplinary team reviewed summary document of what support is available at what level (if created). • Child/youth participated in checklist of needed support/skills to learn while in the Behavioral Rehabilitation Services (BRS) placement. • DHS child/youth's Coordinated Care Organization (CCO) of responsibility was notified if they are moving out of the area. • Child/youth identified Natural Supports with help from the multidisciplinary team, as necessary. • Multidisciplinary team created a plan to identify Natural Supports if none were identified.
License/ Certification	LICENSURE TYPES **Standard Foster Care** • The Department may issue a full certification and Certificate of Approval for up to two years when all assessment activities in OAR 413-200-0274(6) have been completed. • To remain certified, the certified family must submit a completed Application for Renewal or Change of Status, and the Department will assess the certified family every two years. • When the certified family has submitted a timely application for re-certification, the current Certificate of Approval will not expire, despite any expiration date, until the Department has issued a new Certificate of Approval or there is a final order of denial.
Role of County/ Child Placing Agency	DHS contracts with private agencies throughout the state to provide BRS to children with debilitating psychosocial, emotional and behavioral disorders. Behavioral residential treatment facilities provide behavioral intervention, counseling and life skills training. These include therapeutic foster homes, as well as larger residential facilities.
Provider Qualifications and Training *(Including Notable Curriculum Details If*	STATE CHILDREN'S SERVICES AGENCY **Standard Foster Care** **Foster Home Certification:** Be at least 21 years of age (unless a waiver is granted), submit an application, participate in the applicant assessment processes prescribed by the Department, and provide additional information requested by the Department to support the assessment; and be determined by the Department to meet the Standards for

CATEGORY	DESCRIPTION
Available)	Certification of Foster Parents and Relative Caregivers. **Education and Training for Applicants and Certified Families:** An applicant must participate in the Department's orientation prior to receiving a Certificate of Approval or Child-Specific Certificate of Approval, or within 30 days after the placement of a child or young adult in a home that has been issued a Temporary Certificate of Approval. 1. Each applicant and certified family must complete Foundations training before or within 12 months after the date on which the certificate was issued, or provide written documentation of completion of equivalent training content from another licensed child-caring agency within two years of an applicant's dated application for certification if approved as described in Section 6 of this rule. 2. A certified family is exempt from Section 2 of this rule, if a written, individualized training plan, specific to the needs of the child or young adult in the care or custody of the Department placed in the home, has been approved by a certification supervisor and developed within 90 days after a Child-Specific Certificate of Approval or Temporary Certificate of Approval has been issued by the Department. 3. Foundations training is required if an applicant previously certified by the Department has not been certified within the preceding two years unless: (a) Alternative training has been approved under Sections 3 or 4 of this rule; or (b) The certification supervisor waives the training requirement based on the applicant's documented knowledge and skills in caring for a child or young adult placed in the home by the Department. 4. Foundations training is not required if the applicant provides written documentation of completion of equivalent training content from another licensed child-caring agency within two years of an applicant's dated application for certification, and the certification supervisor agrees to waive Foundations training. 5. The certified family and the certifier must develop a training plan for each foster parent or relative caregiver to complete at least 30 hours of training during each two-year certification period, unless a written individualized training plan is developed for a certified family with a Child-Specific Certificate of Approval. This written individualized training plan: (a) Must be designed to strengthen the ability of the certified family to meet the safety, health, and well-being needs of the child or young adult in the care or custody of the Department placed in the home; (b) May be less than the required 30 hours required during a certification period; and (c) Must be approved by a certification supervisor. 6. An applicant or certified family with limited English proficiency or a hearing or visual impairment, who is unable to meet the training requirements outlined in Sections 1–6 of this rule may be provided an individualized training plan prepared by the certifier and

CATEGORY	DESCRIPTION
	approved by the certification supervisor. 7. The Department may require a certified family to complete more than the 30 hours of training for a two-year certification period based on the needs of the child or young adult placed in the home and the knowledge, skills, and abilities of the certified family.
	MEDICAID **Therapeutic Foster Care** Approved provider parent means an individual who a BRS contractor, a BRS provider, or the OYA has approved to provide services or placement related activities to the BRS child/youth in the home of that individual. Approved provider parents who provide services are considered direct care staff, and must meet those qualifications in the BRS Program General Rules in OAR 410-170-0030(4). • Receive a minimum of 28 hours of initial training prior to or within 30 days of employment or certification on the following topics: BRS services documentation, mandatory reporting of child abuse, program policies and expectations, gender- and cultural-specific services, behavior and crisis management, medication administration, discipline and restraint policies and suicide prevention. Any direct care staff, social service staff, or program coordinator who has not yet completed this initial training prior to employment or certification, must be supervised by a person who has completed this training when having direct contact with BRS child/youth. • Receive a minimum of 16 hours of training annually on the following topics: skills-training that supports evidence-based or promising practices, and other subjects relevant to the responsibilities of providing services and placement related activities to the BRS child/youth. • Have and maintain CPR and first aid certification.
Evidence-Based Practices Used *(if applicable)*	TFC Model, which varies based on the type of care provided or the setting of the child. • **Shelter Assessment and Evaluation, Intensive Community Care, Independent Living Service, Community Step-Down, and Independent Living Program:** BRS contractor or BRS provider may use either a residential care model or TFC model. The BRS child/youth is placed in these BRS types of care to identify deficiencies and develop necessary skills. The BRS contractor or BRS provider providing one of these BRS types of care must ensure that a minimum of six hours of services are available per week to each BRS child/youth as follows: (a) one hour of individual counseling or individual skills-training provided by social service staff; and (b) five hours of any combination of individual or group counseling, crisis counseling, skills-training, or parent training. • **TFC, BRS Proctor and Multidimensional Treatment Foster Care:** BRS provider must use a TFC model. The BRS child/youth placed in these BRS types of care requires structure, behavior management, and support services to develop the skills

CATEGORY	DESCRIPTION
	necessary to be successful in a less restrictive environment. The BRS contractor or BRS provider providing one of these BRS types of care must ensure that a minimum of 11 hours of services are available per week to each BRS child/youth as follows: (a) two hours of individual counseling or individual skills-training, one of which is provided by social service staff; and (b) Nine hours of any combination of individual or group counseling, crisis counseling, skills-training or parent training. • **BRS Proctor Day Treatment:** BRS contractor or BRS provider must use a TFC model for this BRS type of care and provide skills-training in a day treatment setting. The BRS child/youth placed in this BRS type of care requires enhanced structure during the day time hours. This level of care provides the structure of day treatment for necessary skill development and a less restrictive home setting with an approved provider parent. The BRS contractor or BRS provider providing this BRS type of care must ensure that a minimum of 11 hours of services are available per week to each BRS child/youth as follows: (a) two hours of either individual counseling or individual skills-training, one of which is provided by social service staff; and (b) nine hours of individual or group counseling, crisis counseling, skills-training or parent training. • **BRS Basic Residential, BRS Rehabilitation Services:** BRS contractor or BRS provider must use a residential care model. The BRS contractor or BRS provider must provide 24-hour supervision of the BRS child/youth by ensuring that at least one direct care staff is on duty and awake whenever a BRS child/youth is present in its program. The BRS child/youth placed in these BRS types of care requires the structure, behavior management, and support services of a residential care model for necessary skill development. • **Intensive Rehabilitation Services, BRS Residential, BRS Enhanced, Short-Term Stabilization Program:** The BRS contractor or BRS provider must use a residential care model for these BRS types of care. The BRS contractor or BRS provider must provide 24-hour supervision of the BRS child/youth by ensuring that at least one direct care staff is on duty and awake whenever a BRS child/youth is present in its program. The BRS child/youth placed in these BRS types of care requires more intensive structure, behavior management and support services than a BRS child/youth in the BRS types of care described in Section 4 of this rule. • **Enhanced TFC:** The BRS contractor or BRS provider must use a TFC model. The BRS child/youth placed in this BRS type of care can be maintained in a home of an approved provider parent with structure, behavior management and enhanced supports. The BRS child/youth placed in this BRS type of care has difficulty in a group setting and requires a placement utilizing a TFC model. The BRS contractor or BRS provider providing this BRS type of care must ensure that a minimum of 13 hours of services are available per week to each BRS child/youth as follows: (a) two hours of either individual counseling or individual skills-training, one of which is provided by social service staff; and (b) 11 hours of any combination of individual or group counseling, crisis counseling, skills-training, or parent training.

<table>
<tr><th>CATEGORY</th><th colspan="6">DESCRIPTION</th></tr>
<tr><td>Required Interventions/ Program Elements</td><td colspan="6">See Program Overview and Evidence-Based Practices Used.</td></tr>
<tr><td rowspan="3">Medicaid Delivery System[23]</td><td colspan="3">Delivery System for SMI/SED</td><td colspan="3">Delivery System for Foster Care[24]</td></tr>
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<tr><td>Medicaid Provider of TFC Services (if applicable)</td><td>☐ State/ County Children’s Agency</td><td>☒ Child Placing Agency</td><td>☒ Foster Parent</td><td>☐ BH Services Organization/ Clinician</td><td>☐ Waiver Case Management Entity</td><td>☐ Not Applicable or Other</td></tr>
<tr><td>Payment Methods and Rates for TFC Services (if applicable)</td><td colspan="6">STATE CHILDREN’S SERVICES AGENCY
N/A

MEDICAID
TFC reimbursed under HCPCS Code S5146 for children/youth under 21 years of age.</td></tr>
</table>

[23] In 2012, Oregon launched a new managed care model with risk-bearing, locally-governed provider networks called Coordinated Care Organizations (CCOs). These entities provide all Medicaid enrollees with physical health services, as well as BH and dental care which were formerly carved out of the Oregon Health Plan benefit package. The CCOs are paid a single global Medicaid budget that grows at a fixed rate, while allowing for some flexibility in the services that a plan provides. The CCOs will be held accountable for performance based metrics and quality standards that align with industry standards, new systems of governance, and payment incentives that reward improved health outcomes.

[24] Children in foster care may voluntarily enroll in Medicaid managed care. However, children in foster care are mandatorily enrolled in the Community Behavioral Health Services Program, the BH benefit managed by PIHPs.

TENNESSEE: THERAPEUTIC FOSTER CARE

CATEGORY	DESCRIPTION
Service Title/ Program Name	Therapeutic Foster Care
Program Overview	**STATE CHILDREN'S SERVICES AGENCY** Department of Children's Services (DCS) TFC Services provide safe, nurturing care and guidance in private homes when children/youth are unable to receive the parental care they need in their own home. The child/youth is integrated fully into the community and provided opportunities for participation in community and extracurricular activities as well as development of talents, interests and hobbies. The placement will be in a home-like, least restrictive setting that meets the unique need of the child/youth with respect to their community/school district and placed with siblings, if possible. The foster parents receive standard foster parent training and are supervised and supported by agency staff, working together to meet the goal of permanency based on the best interest of the child. The families of children in foster care are offered support services to facilitate reunification whenever appropriate. The child/youth requires a higher level of clinical support, intervention and case coordination than those eligible for standard foster care. Their emotional/behavioral needs within the family are met through care by parents who have received standard foster parent training as well as specialized training to meet the higher therapeutic needs of the children/youth they serve. Moreover, the child/youth's emotional/behavioral clinical needs are moderate and can be met through community and/or outpatient services. **MEDICAID** N/A
Medical Necessity Criteria/ Program Eligibility	**STATE CHILDREN'S SERVICES AGENCY** Children/youth appropriate for TFC: 1. Are unable to receive the parental care they need in their own home. 2. Appear to be capable of participating in a family unit and able to participate in family and community activities without posing a serious danger to themselves or others. 3. May be of any adjudication type and are not excluded from admission when their risk is low or they have successfully completed a treatment program. For information about youth adjudicated delinquent in foster care, refer to DCS Policy 16.46 Child/Youth Referral and Placement. 4. May have a history of moderate mental health, and behavioral concerns that require

CATEGORY	DESCRIPTION
	monitoring or observation to prevent an increase in severity. Youth may have current emotional or behavioral symptoms which are moderate or transiently severe in nature. These may manifest themselves in difficulty coping socially, occupationally or in school functioning. 5. Have a CANS recommending Level 2 or Level 3 services. The child/youth scores a two or three within the domain of child behavioral or emotional needs, such as psychosis, anxiety, adjustment to trauma and an elevated rating on either life domain functioning or child risk behaviors.
	MEDICAID N/A
License/ Certification	LICENSURE TYPES Through agreements with Child Placing Agencies, the DCS Office of Child Welfare Licensing regulates child placing agencies and private foster care programs. Foster homes are reevaluated annually.
Role of County/ Child Placing Agency	Roles and responsibilities of Child Placing Agencies are described in the Contract Provider Manual, Section 2 – Standard Foster Care Services. The Manual also contains DCS policy regarding Therapeutic Foster Care Services.
Provider Qualifications and Training *(Including Notable Curriculum Details If Available)*	STATE CHILDREN'S SERVICES AGENCY **Foster Parent Training** Child placing agencies approve foster homes upon successful completion of a home study and meeting required specified in Chapter 0250-4-9 Standards For Child-Placing Agencies. Foster homes are reevaluated annually. Foster homes shall not have more than six children including the foster parents' own children. Child placing agencies require foster parents to participate in ongoing training including parenting techniques and discipline and the detection, intervention, prevention, and treatment of child sexual abuse. **Therapeutic Foster Care** In addition to the Standard Foster Care pre-service training, all newly approved therapeutic foster parents are required to complete additional hours of specialized training targeted toward the population to be served (i.e., mental health, juvenile justice) prior to caring for the children/youth. • Juvenile Justice: nine hours of Juvenile Justice Training — Parenting the Youthful

CATEGORY	DESCRIPTION
	Offender Curriculum • Mental Health: 15 hours of behavioral/mental health oriented training.[25] • Additionally, therapeutic foster parents will receive specialized training on the specific mental health or behavioral needs of each child/youth to be placed in their home. Foster parents providing continuum foster care services have the maturity to be able to care for children/youth needing this higher level of service. It is recommended that these foster parents be at least 25 years of age. If the foster parent is not at least 25 years of age, the agency can still approve the parent by documenting that the parent has shown the maturity to be able to perform these services. Documentation can take the form of letters of reference and interviews discussing this issue specifically. Currently approved parents not meeting this age limit will remain approved (grandfathered in). **Agency Staff Training** Contract provider case managers will complete specialized pre-service training targeted toward the population they will serve.
	MEDICAID Unable to identify information in online materials regarding Medicaid TFC provider qualifications.
Evidence-Based Practices Used *(if applicable)*	The State of Tennessee does not mandate a specific TFC model, although the ongoing state collaborative aims to develop one. All provider agencies adhere to a standard scope of services that specifies the responsibilities and services of both the agency and the TFC parents.
Required Interventions/ Program Elements	**Agency Responsibilities and Services:** Provide safe, stable care in a nurturing environment; provide guidance, structure, protection and offer participation/inclusion in as many positive experiences as possible; work constructively within the policy framework in developing plans and meeting the needs of the child and his/her family; provide information to the agency regarding the needs of a child in care; accept and use professional

[25] Fifteen (15) hours of behavioral/mental health oriented training which addresses at a minimum the following topics: Policy and Procedures, Protocol/Professional Expectations for Foster Parent, What is behavioral/mental health foster parent care?, YOUR RIGHTS as a Foster parent, Confidentiality, Emergencies, Additional Services and assistance in home care, Education services for child that is behavioral/mental health, Engaging families and birth parents, Common Conditions of Children, Understanding Growth and Development, Trauma and its effects on the child/youth, Mental Health Support, Preparing for the child/youth to leave home, and Self-Care for Caregivers.

<table>
<tr><th>CATEGORY</th><th colspan="4">DESCRIPTION</th></tr>
<tr><td></td><td colspan="4">consultation including mental health and educational assistance; participate fully in therapeutic and medical services provided for the child/youth; participate fully in social and educational services; provide opportunities for the child to participate in appropriate extra-curricular activities; provide developmentally appropriate activities and support designed to prepare the child/youth to lead self-sufficient adult lives, in accordance with their service plan; encourage maintenance of contact with the child/youth's family or "circle of support" and provide support in making such arrangement; assist in maintaining the relationship with siblings through visits; provide routine transportation for the child/youth placed in their home; maintain confidentiality; work in partnership with the agency DCS; assist in preparing the child/youth for return home or for placement in a stable, nurturing, permanent environment.

Foster Family Responsibilities and Services: Share all available pertinent information regarding the child/youth's record with the foster family; prepare the child/youth for placement to help with adjustment; provide case management and coordination of services; assist in preparing the child/youth for return home or for other placement; assist and support the child in receiving outpatient therapy, if indicated, up to twice monthly; assist and support the child in receiving medication management, if indicated; coordinate health services; provide educational liaison to interact with the child/youth's educational needs and Individual Education Plans; provide recreational activities, daily living skills and interdependent living skills; provide information to DCS about family activities and progress toward the goal of permanency; provide services to help the child's permanency family maintain and enhance parental functioning, parental care, and parental ties unless the child/youth's safety would be compromised; meet with the child/youth's parent(s) without the child/youth at least one time per month; assess and support the achievement of permanency; provide board rates that meet or exceed the basic board rates outlined in DCS Policy 16.29, Foster Home Board Rates and DCS Policy 16.8, Responsibilities of Approved Foster Homes, and Protocol for Respite Care and Other Events.</td></tr>
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CATEGORY	DESCRIPTION					
Financing Sources for TFC Services	☒ IV-E	☒ Medicaid Treatment (including TCM)	☐ Medicaid Administrative	☐ State General Fund	☐ County	☐ Other
Medicaid Provider of TFC Services *(if applicable)*	☐ State/ County Children's Agency	☒ Child Placing Agency	☐ Foster Parent	☒ BH Services Organization/ Clinician	☐ Waiver Case Management Entity	☐ Not Applicable or Other
Payment Methods and Rates for TFC Services *(if applicable)*	STATE CHILDREN'S SERVICES AGENCY **DCS Rates to Provider Agencies:** • Level II family setting: – Standard: $120; Special needs and SUDs: $135–$150 • Level III family setting: – Standard: $175; Special needs, SUD, sex offenders: $200–$300					
	MEDICAID TFC is financed in Tennessee through both DCS and TennCare funds. The majority of youth entering foster care are eligible for TennCare Select, which functions as an MCO operated by BlueCross BlueShield of Tennessee, through an immediate eligibility system. TFC is not a TennCare covered benefit except under its contract with DCS. TennCare contracts with DCS to provide funding for all children in custody as well as for pre-custodial investigative work. DCS oversees distribution of these funds as well as federal IV-E funding; the two funding streams are used to cover distinct aspects of TFC, including clinical/therapeutic services (Medicaid) and board care and training and recruitment efforts of the provider agencies (IV-E). Medicaid funds are used only to pay for Medicaid-covered clinical and therapeutic services.					

TEXAS: INTENSE FOSTER FAMILY CARE

CATEGORY	DESCRIPTION
Service Title/ Program Name	Intense Foster Family Care
Program Overview	STATE CHILDREN'S SERVICES AGENCY The Intense Service Level consists of a high degree of structure, preferably in a family, to limit the child's access to environments, as necessary to protect the child. The caregivers have specialized training to provide intense therapeutic and habilitative supports and interventions with limited outside access, including: 24-hour supervision to ensure the child's safety and sense of security, which includes frequent one-to-one monitoring and the ability to provide immediate on-site response; affection, reassurance, and involvement in therapeutic activities appropriate to the child's age and development to promote the child's well-being; contact, in a manner that is in the child's best interest, with family members and other persons significant to the child in order to maintain a sense of identity and culture; therapeutic, habilitative, and medical intervention and guidance that is frequently scheduled and professionally designed and supervised to help the child achieve functioning more appropriate to the child's age and development; and consistent and frequent attention, direction, and assistance to help the child achieve stabilization and connect appropriately with the child's environment. In addition to the description above, a child with developmental delays or intellectual disabilities needs professionally directed, designed, and monitored interventions to enhance: mobility; communication; sensory, motor and cognitive development; and self-help skills. A child with primary medical or habilitative needs requires frequent and consistent interventions. The child may be dependent on people or technology for accommodation and require interventions designed, monitored or approved by an appropriately constituted interdisciplinary team. MEDICAID The Texas STAR Health Contract, the Medicaid MCO responsible for children in the foster care and other systems, does not describe requirements for TFC services or programs.
Medical Necessity Criteria/ Program Eligibility	STATE CHILDREN'S SERVICES AGENCY Children who need intense services and have severe problems in one or more areas of functioning that present an imminent and critical danger of harm to self or others, such as: behaviors that include: extreme physical aggression that causes harm, recurring major self-injurious actions, including suicide attempts, other difficulties that present a critical risk of harm to self or others, or severely impaired reality-testing, communication skills, cognition, expressions of affect, or personal hygiene; abuse of alcohol, drugs, or other conscious-altering substances that involves a primary diagnosis of substance dependency

CATEGORY	DESCRIPTION
	in addition to being extremely aggressive or self-destructive to the point of causing harm; developmental delays or intellectual disabilities marked by: impairments so severe in conceptual, social, and practical adaptive skills that the child's ability to actively participate in the program is limited and requires constant one-to-one supervision for the safety of self or others, or a consistent inability to cooperate in self-care while requiring constant one to one supervision for the safety of self or others; or primary medical or habilitative needs that present an imminent and critical medical risk and require assistance with: frequent acute exacerbations and chronic, intensive interventions related to the diagnosed medical condition, inability to perform daily living or self-care skills or 24-hour on site medical supervision to sustain life support. The provider arranges for or ensures: the same medical and dental services that are required at the Specialized Service Level; a written plan, agreement, or contract with medical personnel to provide 24-hour, on-call medical, nursing and psychiatric services based on the child's needs identified in the child's service plan. The plan or agreement for medical, nursing and psychiatric services shall include provisions for timely access to services in emergencies. The plan or agreement must also be sufficient to ensure appropriate monitoring of chronic illnesses; and services, as appropriate, for a child with developmental disabilities, intellectual disabilities, or primary medical or habilitative needs, including: 24-hour medical or nursing supervision, 24-hour availability of nursing, medical, and psychiatric services, and one-to-one supervision while medical and dental services are being provided.
	MEDICAID The Texas STAR Health Contract, the Medicaid MCO responsible for children in the foster care and other systems, does not describe requirements for TFC services or programs.
License/ Certification	LICENSURE TYPES **Standard Foster Care** Independent family foster families must receive a license pursuant to standards of the Department of Family and Protective Services. An initial license is described in guidance documents, but no additional information regarding the duration of licensure was identified in online materials. **Treatment/Therapeutic Foster Care** No additional training identified. *See* Program Overview.
Role of County/ Child Placing	Minimum Standards for Child Placing Agencies set forth the rules that apply to child-

CATEGORY	DESCRIPTION
Agency	placing agencies.
Provider Qualifications and Training *(Including Notable Curriculum Details If Available)*	STATE CHILDREN'S SERVICES AGENCY **Foster Parent Training** Foster parents must receive two hours of pre-service training before a child can be place in their care. Twenty hours of annual training is required and must include: • One hour of training on prevention, recognition, and reporting on child abuse and neglect. This requirement does not apply to executive directors; • Two hours of training specific to trauma informed care; • Two hours of training specific to normalcy; and • Two hours of transportation safety training if the person transports a child placed in a foster group home whose chronological or developmental age is younger than nine years old. Child placing agencies may also establish additional training requirements. **Agency Staff Training** In addition to the training requirements at the Moderate Service Level, new caregivers without previous experience in residential childcare may not be assigned sole responsibility for any child until the new caregiver has been supervised for at least 40 hours while conducting direct childcare duties. An experienced caregiver must be physically available to each new caregiver at all times, until the new caregiver acquires the supervised experience. The provider must document the supervised childcare experience of every caregiver who provides direct care to children. All caregivers, except caregivers in foster homes verified by child-placing agencies, must receive 50 hours of training each year. Caregivers in foster homes verified by child-placing agencies must meet the following requirements: For homes with two or more caregivers, each caregiver must receive at least 30 hours of training. For homes with one caregiver, the caregiver must receive at least 50 hours of training. MEDICAID The Texas STAR Health Contract, the Medicaid MCO responsible for children in the foster care and other systems, does not describe requirements for TFC services or programs.
Evidence-Based Practices Used *(if applicable)*	No state-level evidence-based practice model was identified in online materials. Each child placing agency may establish their own criteria.

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The state created an Intense Plus level primarily for facilities serving high needs children. In addition, there is an Intense wrap service that is offered, but offered by an agency to a family. Intense wrap services are not ones that the foster parent can provide him or herself and receive reimbursement.
• Child Placing Agency:
– Daily Rate = $186.42
– IV-E Allowable Rate: = $86.78</td></tr>
</table>

[26] On April 1, 2008, the Health and Human Services Commission launched the STAR Health Foster Care program as the first comprehensive health and medical network for children who are in the state’s foster care system. The goal is to give children health care services that are coordinated, comprehensive, easy to find and uninterrupted when the child moves. The MCO must provide or arrange for the delivery of all Medically Necessary community-based, rehabilitative and inpatient hospital BH Services. BH services include covered services for the treatment of mental, emotional or clinical dependency disorders.

CATEGORY	DESCRIPTION
	MEDICAID Unable to identify Medicaid payment related to TFC.

VIRGINIA: TREATMENT FOSTER CARE

CATEGORY	DESCRIPTION
Service Title/ Program Name	Treatment Foster Care
Program Overview	STATE CHILDREN'S SERVICES AGENCY Treatment Foster Care means a community-based program where services are designed to address the special needs of children. Services to the children are delivered primarily by treatment foster parents who are trained, supervised and supported by agency staff. Treatment is primarily foster family-based and is planned and delivered by a treatment team. Treatment foster care focuses on a continuity of services, is goal-directed and results oriented and emphasizes permanency planning for the child in care. The term "special needs" in this definition refers to the child's emotional, behavioral, educational, nutritional and medical needs. The State of Virginia uses Intensive Care Coordination (ICC) and the High Fidelity Wraparound (HFW) Model[27] for youth with challenging BH issues and who are at-risk of out-of-home placement. The HFW is based on the following principles: • Individualized and family and youth driven services • Strengths-based practice • Reliance on natural supports and building self-efficacy • Team-based practice • Outcomes-based service planning • Cultural and linguistic competence The model uses a short-term crisis stabilization plan and then more long-term planning based on an assessment of the child's strengths and needs. ICC/HFW is a team-oriented approach that seeks to engage the youth, build on family strengths and integrate planning. That differs from both a traditional clinical service and traditional case management. External evaluation has validated the efficacy of this model. Evaluation of a similar

[27] Meeting the Needs of High Needs Children in the Texas Child Welfare System, The Stephen Group, November 2015.

CATEGORY	DESCRIPTION
	wraparound system in Maine has found as many as 82% were able to move to less restrictive environments after 18 months compared to 38% of the comparison group.
	MEDICAID N/A
Medical Necessity Criteria/ Program Eligibility	STATE CHILDREN'S SERVICES AGENCY To meet criteria for TFC, children/youth must meet all three of the following conditions: 1. Children in foster care under the age of 21. 2. Children experiencing a behavioral disorder or emotional disturbance. 3. A Family Assessment and Planning Team (FAPT) referral: A. The FAPT is a multidisciplinary team that considers the needs and strengths of youths and families, identifies and reviews the service plan, and makes recommendations to ensure the plan builds on the family's strengths and needs. B. The FAPT consists of parent representatives, private providers, and staff from DHS (includes Behavioral Health, Physical Health and social services), court service units and schools. Treatment foster care is indicated when a child/youth meets the following criteria: 1. CANs indicates the appropriateness of an intensive level of care (e.g., emotional/ behavioral needs, risk behaviors, etc.), and[28] 2. Virginia Enhanced Maintenance Assessment Tool (VEMAT) indicates the need for a high-level of daily supervision. Enhanced maintenance payments are available when a child has a clearly-defined need that requires the parent to provide increased support and supervision due to the child's behavioral, emotional or physical/personal care requirements. Title IV-E and state funds shall only be claimed for enhanced maintenance payments when the Local Department of Social Services (LDSS) uses the VEMAT to determine the need for and amount of enhanced maintenance. The VEMAT shall be used by the LDSS for any child placed in TFC homes. Treatment foster care must be recommended by the FAPT/Multi-Disciplinary Team and included in the Individual and Family Support Program. Procedures for emergency placement must be followed. *NOTE: When placing sibling groups, levels of service must be matched to the individual*

[28] Guidelines for the Use of Treatment Foster Care Under the Comprehensive Services Act, State Executive Council for The Comprehensive Services Act, Adopted April 18, 2012.

CATEGORY	DESCRIPTION
	needs of each individual child. Treatment Foster Care Levels 1, 2 and 3 represent ongoing treatment placement levels, with Level 1 representing the lowest treatment needs, Level 2 moderate treatment needs and Level 3 significant treatment needs. • **Level 1 Treatment Foster Care:** The needs of a child served at Level 1 ongoing treatment foster care require monitoring or the Licensed Child-Placing Agency may need to provide services to lessen the likelihood that identified needs will become more acute or return after being "resolved". Children served at Level 1 will typically demonstrate a relatively low level of social/ emotional/behavioral/medical/personal care needs or impairment for normal range of age and development. *Areas of need may include but not be limited to, depression, anxiety, impulsivity, hyperactivity, anger control, adjustment to trauma, oppositional, substance use, eating disorder, physical health condition, developmental delay or intellectual disability.* • **Level 2 Treatment Foster Care:** The needs of a child served at Level 2 ongoing treatment foster care require that significant action (interventions, services, supports, etc.) be taken to address, remedy or ameliorate the identified needs. Children served at Level 2 will typically demonstrate a relatively moderate level of social/emotional/ behavioral/ medical/personal care needs or impairment for normal range of age and development. *Areas of need may include but not be limited to, depression, anxiety, impulsivity, hyperactivity, anger control, adjustment to trauma, oppositional, substance use, eating disorder, physical health condition, developmental delay or intellectual disability.* • **Level 3 Treatment Foster Care:** The needs of a child served at Level 3 ongoing treatment foster care are of such acuity or severity that they require intensive action (interventions, services, supports, etc.) be taken to address, remedy or ameliorate the needs. Without such intervention the child may be at-risk of residential placement. Children served at Level 3 will demonstrate a high-level of social/emotional/behavioral/ medical/personal care needs or impairment for normal range of age and development. *Areas of need may include but not be limited to, depression, anxiety, impulsivity, hyperactivity, anger control, adjustment to trauma, oppositional, substance use, eating disorder, physical health condition, developmental delay or intellectual disability.*
	MEDICAID N/A
License/ Certification	LICENSURE TYPES STANDARD FOSTER CARE Foster parents are approved DSS to provide 24-hour foster care services. No more than eight children can be in the provider's home unless a variance is granted. TREATMENT/THERAPEUTIC FOSTER CARE TFC parents are approved by the licensed or certified child-placing agency and trained to

CATEGORY	DESCRIPTION
	provide treatment foster care services.
Role of County/ Child Placing Agency	Licensed child-placing agencies operate within standards and guidelines that describe their roles and functions.
Provider Qualifications and Training *(Including Notable Curriculum Details If Available)*	STATE CHILDREN'S SERVICES AGENCY **Foster Parent Training** Foster parents receive pre-service training. Certain curricula have been verified to meet the required competencies: Parent Resources for Information, Development and Education (PRIDE), Model Approach to Partnerships in Parenting (MAPP), and Parents as Tender Healers (PATH). The Department supports PRIDE as the preferred curriculum. All other curricula must be approved by the Virginia DSS in order to satisfy the pre-service requirement. **Pre-service training** must address, but not be limited to, the following core competencies described in full in the Local Department Resource, Foster, And Adoptive Family Home Approval Guidance. Additional training areas are also required to be included in pre-service training and specified in the Guidance. **In-service training is an annual requirement** and families should be surveyed no less than annually to determine training needs. **TFC Training** TFC parents are approved by the licensed or certified child-placing agency and trained to provide treatment foster care services.
	MEDICAID N/A
Evidence-Based Practices Used *(if applicable)*	*See* Provider Qualifications and Training.
Required Interventions/ Program Elements	**Agency Responsibilities and Services:** comprehensive assessment of the child's emotional, social, behavioral, educational, nutritional, developmental, medical, psychiatric and dental needs; develop and implement an individualized service plan; prescribe levels of care, specify minimum training requirements for all treatment foster care parents including the minimum number of hours and content; actively support the family engagement policy of the placing locality; provide additional training to each professional staff person who has responsibility to work with children and their families or to supervise staff persons who work with children and their families. In addition, the child placing agency must provide training, support, and guidance to foster families in implementing the

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An additional responsibility is the provision of Treatment Foster Care Case Management, a component of treatment foster care through which a case manager provides treatment planning, monitors the treatment plan, and links the child to other community resources as necessary to address the special identified needs of the child. Treatment Foster Care Case Management focuses on a continuity of services that is goal-directed and results-oriented. The provision of services will vary for each child based on that child's specific needs and the identified level of care.

Non-Covered Services Activities: Permanency planning and other activities performed by foster care workers shall not be considered covered services and shall not be reimbursed.</td></tr>
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[29] TFC Case Management is a non-traditional service which is covered through Magellan. All traditional BH services are covered through the MCO.

[30] Financing for Treatment Foster Care:

SERVICE	LEVEL 1 TFC	LEVEL 2 TFC	LEVEL 3 TFC
Foster Care Maintenance	IV-E/CSA	IV-E/CSA	IV-E/CSA
Enhanced Maintenance	Per VEMAT, IV-E/CSA	Per VEMAT, IV-E/CSA	Per VEMAT, IV-E/CSA

CATEGORY	DESCRIPTION					
Medicaid Provider of TFC Services *(if applicable)*	☐ State/ County Children's Agency	☒ Child Placing Agency	☐ Foster Parent	☐ BH Services Organization/ Clinician	☐ Waiver Case Management Entity	☐ Not Applicable or Other

Payment Methods and Rates for TFC Services *(if applicable)*

STATE CHILDREN'S SERVICES AGENCY

Foster Maintenance Payment Rates:

AGE OF CHILD	TOTAL PAYMENT RATE
0–4	$ 471.00
5–12	$ 552.00
13 and over	$ 700.00

MEDICAID

TFC Case Management: The service limit is 1 unit = 1 calendar month. The monthly rate is $326.50/unit.

WASHINGTON: TREATMENT FOSTER CARE

CATEGORY	DESCRIPTION
Service Title/ Program Name	Treatment Foster Care
Program Overview	STATE CHILDREN'S SERVICES AGENCY TFC is provided directly through the Department of Children and Family Services (DCFS) licensed foster homes and by contract or agreement with other agencies. There are four levels of foster care based on the age of the child; the behavioral, emotional, physical and mental health needs of the child; and the foster parents' ability to meet those needs. Within those levels are three different age categories; 0–5; 6–11; and 12 and older.[31]

Support/Supervision	CSA	CSA	CSA
TFC Case Management	Medicaid*/CSA	*Medicaid/CSA	*Medicaid/CSA[30]

[31] A Foster Parent Guide to Foster Care Rate Assessment, DSHS Children's Administration, January 2014

CATEGORY	DESCRIPTION
	Level 1: Foster parents can meet the needs of these children within the timeframes of a typically developing child. **Level 2:** Children assessed at Level 2 most often have issues requiring more time and attention than those at Level 1, such as specific behavioral and emotional issues or intellectual challenges. **Levels 3 and 4:** Children assessed at Levels 3 and 4 comprise less than 5% of children in foster care. These children require a lot more time from the foster parent because of behavioral issues needing intervention; psychiatric issues; severe mental health disorders; ongoing drug/alcohol involvement; behaviors that require a safety plan; or behaviors that have resulted in a child being unable to stay in one home for very long, among others. Level 3 and 4 children often participate in more than one treatment program.[32] Out-of-home care providers, such as foster parents and staff of licensed group homes, are part of the professional team working to complete the permanency plan for the child and his or her family. (Other team members will vary by child but should include the social worker, a parent and relatives when possible, school district personnel, therapist and other concerned adults.) Care providers are expected to contribute to development of the child's permanent plan and to engage in activities that support achieving the permanent plan.[33] Therapeutic or treatment foster homes are those licensed foster families that have been identified to care for extremely behaviorally/emotionally disturbed children who cannot function in a family home without specialized treatment and expertise.[34] TFC is provided directly through DSHS licensed foster homes and by contract or agreement with other agencies. These services do not include those accessed through Rehabilitative Treatment Services.[35]

[32] Ibid.

[33] Appendix D, Behavior Management Guidelines, Department of Social and Health Services Behavior Rehabilitation Services Contractor Handbook

[34] Section 4532. Therapeutic or Treatment Foster Care

[35] BRS is a temporary intensive wraparound support and treatment program for youth with high-level service needs. BRS is used to stabilize youth (in-home or out-of-home) and assist in achieving their permanent plan. BRS services are intended to: safely keep youth in their own homes with wraparound supports to the family, safely reunify or achieve alternative permanency more quickly, safely meet the needs of youth in family-based care to prevent the need for

CATEGORY	DESCRIPTION
	• Treatment foster homes are limited to no more than six children, per the minimum. • Each treatment foster home must operate within the capacity stated in its license. • Treatment foster homes have no more than four of their own minor children or non-TFC children, in the home. • No more than three TFC foster children are placed in a foster home at one time, unless a sibling group is to be placed together or there is a therapeutic basis for the placement of more than three children in the home. All placements in excess of three TFC children must have the approval of the CA Regional Administrator, or designee.
	MEDICAID N/A
Medical Necessity Criteria/ Program Eligibility	STATE CHILDREN'S SERVICES AGENCY Eligibility is determined, in accordance with regional procedures, following assessment of service and placement options.
	MEDICAID N/A
License/ Certification	LICENSURE TYPES **Standard Foster Care** To be considered for a foster care license, an applicant must: be at least 21 years of age; have sufficient income to support themselves without relying on foster care payments; discipline children in a positive manner without the use of physical punishment; provide supervision appropriate to the age or specific behavior of the child as outlined by the social worker; and complete training (i.e., First Aid/CPR, Blood Borne Pathogens, Licensing Orientation, and Pre-service Training).[36] Licenses are valid for a three-year period. **Therapeutic Foster Care** Licensed foster families identified to care for extremely behaviorally/emotionally disturbed children who cannot function in a family home without specialized treatment and expertise. Therapeutic foster parents have specialized skills in managing these children. Often these

placement into a more restrictive setting, and safely reduce length of service by transitioning youth to a permanent home or less intensive service.

[36] Becoming a Foster Parent, DSHS website at https://www.dshs.wa.gov/CA/fos/becoming-a-foster-parent

CATEGORY	DESCRIPTION
	homes have a pre-determined, designated intensive "package" of services that are delivered to every child placed in the therapeutic foster home.
Role of County/ Child Placing Agency	Responsibilities of the CPA are contained in Minimum Licensing Requirement for Child Placing Agencies.
Provider Qualifications and Training *(Including Notable Curriculum Details If Available)*	STATE CHILDREN'S SERVICES AGENCY **Foster Parent Training** Foster parent training requirements: • Orientation: in-person or online. • Pre-Service training: 24-hours and a CPR course. • Ongoing training: Annual training (36 hours during first three-year licensing period; 30 hours during second three-year licensing period; and 24-hours during all subsequent three-year licensing periods. Foster parents shall complete all Division of Licensed Resources (DLR) required foster parent trainings before placement of children in the home. The contractor shall develop, monitor, and annually assess training plans for treatment foster parents. Each foster parent must obtain 30 hours of training annually. Foster parents may not carry over excessive training hours to the next period. Topics offered may be based on foster parents' needs for skill development, and the issues of the children they are serving. Foster parents are required to take Medication Management training. Prior to placing a sexually aggressive youth (SAY) or physically aggressive assaultive youth (PAAY) with a foster parent(s), that foster parent(s) shall have specific training to address the safety and supervision of SAY or PAAY youth. This training can be obtained through DLR in a classroom setting, online or by the Contractor using a DVD provided upon request. Online trainings can be accessed at: http://allianceforchildwelfare.org/content/training-videos. The contractor shall provide monthly meetings for informal support and training for foster parents. MEDICAID N/A
Evidence-Based Practices Used *(if applicable)*	See course catalog for in-service, foundation and focused training topics. Training is organized according to relevance for caregivers, support staff, social workers and supervisors.
Required Interventions/ Program	Varies based on level of care and child-specific needs.

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The Foster Care Rate Reimbursement has four levels. These levels are based on the age of the child; the behavioral, emotional, physical and mental health needs of the child; and the foster parents’ ability to meet those needs. Within those levels are three different age categories: 0–5, 6–11 and 12 and older. The older the child, the higher the reimbursement rate, regardless of factors listed above.

Level 1 is the basic amount of care provided to any child based on the child’s age, still recognizing each child has individual needs.

Levels 2, 3 and 4 represent increased levels of non-routine caretaking provided by the foster parent.</td></tr>
</table>

[37] Children in foster care (as well as former foster children ages 18–26) are eligible for enrollment under the Washington State Apple Health Foster Care MCO. Apple Health Foster Care plans are responsible for BH services. The contract describes eligible BH providers based on professional licensure and certification requirements being met. Neither foster families nor child placing agencies are listed as eligible providers of BH services.

CATEGORY	DESCRIPTION
	"Non-routine caretaking" means the foster parents' extra time and effort beyond typical care needed to meet a child's additional needs. The definition is not directly based on a child's diagnosis or condition, although that diagnosis or condition could create extra demands on the foster parent that can be reimbursed.

SERVICE/LEVEL	RATE EFFECTIVE 12/1/2017	
CPA Foster Care Level 1	Age <6	$ 562.00
	Age 6 through 11	$ 683.00
	Age 12 or older	$ 703.00
CPA Foster Care Level 2		$ 177.92
CPA Foster Care Level 3		$ 523.51
CPA Foster Care Level 4		$ 802.30

MEDICAID

Treatment foster care services are not discussed in the Washington Apple Health Foster Care MCO Contract.

WISCONSIN: TREATMENT FOSTER CARE

CATEGORY	DESCRIPTION
Service Title/ Program Name	Treatment Foster Care (Moderate, Specialized, Exceptional)
Program Overview	STATE CHILDREN'S SERVICES AGENCY Wisconsin Department of Children and Families **Moderate Treatment Foster Care:** Level 3 certification is considered moderate treatment foster care, which is foster care that can provide additional supervision and care to children with higher needs than those in basic foster care.[38] **Specialized Treatment Foster Care:** Level 4 certification is considered specialized treatment foster care, which is structured to meet the higher needs of children and often addresses specific population needs, such as teen parents or youth with sexually aggressive behaviors. **Exceptional Treatment Foster Care:** Level 5 certification is considered exceptional treatment foster care, and is also sometimes referred to as "shift-staffed" foster care. These foster homes have staff members who work in rotating shifts to care for the children. Level 5 foster homes are generally created to meet the needs of specific children who need care into adulthood and the home becomes the adult resource. MEDICAID **Children's Foster Homes and Treatment Foster Homes:** A Children's Foster Home is a family oriented residence operated by a person licensed under §48.62, of the Wisconsin Statutes, and DHS 56 of the Administrative Code as a Foster Home, or residences operated by a provider licensed under DHS 38 of the Administrative Code as a Treatment Foster Home. Children's Foster Homes and Treatment Foster Homes provide care and maintenance for no more than four foster children, with exceptions for more children if the children in foster care are siblings. Services provided by these homes are for children who need support in one or more aspects of their lives including health care; personal care; supervision; behavior and social supports, daily living skills training and transportation.
Medical Necessity Criteria/	STATE CHILDREN'S SERVICES AGENCY The level of care certification does not necessarily need to match the level of need of a child placed in the home. The CANs tool will help determine the type of service provision

[38] Level 1 certification is reserved for child-specific licenses only. Level 2 foster care is referred to as basic foster care.

CATEGORY	DESCRIPTION
Program Eligibility	needed to support a placement at a lower assessed level for a child. Per DCF 56.22. Assessment of needs and strengths, "a placing agency shall use a standardized assessment tool prescribed by the Department to assess the needs and strengths of a child placed or to be placed into a foster home and the needs of the child's foster parent. A placing agency may subcontract this responsibility."
	MEDICAID Children's Long-Term Support (CLTS) Waiver[39] participants must meet the functional and support needs criteria, as set forth in the CLTS Functional Screen, meet Medicaid financial

[39] The overall purpose of Wisconsin's CLTS Waiver Program is to provide necessary supports and services to children from birth through age 21 in the State of Wisconsin with significant disabilities who meet functional, Medicaid financial and non-financial requirements, and reside in allowable living situations within the community to prevent placement in an institutional setting. The CLTS Waiver Program is a component of Wisconsin's support system for children with disabilities. The goal of the CLTS Waiver Program is to support children with substantial needs, as well as their parents/guardians, by delivering services to assure the child's health, safety and welfare needs in an inclusive home and community setting. A key tenet of the CLTS Waiver Program is that children are best served within the context of their family and community.

Wisconsin's CLTS system is guided by the following vision and principles which were developed in collaboration with families, advocates, providers and waiver agencies:

- The focus is on the child and his/her strengths and needs.
- Children remain in the home with their families whenever possible.
- Parents have a great capacity to care for their child with a disability if provided the supports they need.
- The service system enhances the natural supports received from family, friends, neighbors and volunteers.
- Quality service coordination supports culturally competent practices and innovative approaches to engaging children and families in their community.
- Collaboration amongst interconnected support systems enhances the provision of quality care.

The CLTS Waiver Program is operated by county waiver agencies, which are county government agencies that have the ability to levy taxes through both property and county sales tax processes.[39] These funds, if utilized through the waivers, are transferred through intergovernmental transfer and tracked through the Data Warehouse and CARS (State of Wisconsin, Department of Health Services reporting system) and a county waiver agency must show adequate non-federal match in order to claim the federal financial participation. Wisconsin Statute 46.22 gives counties authority to levy taxes for social service expenditures.

Wisconsin's CLTS organizational structure supports families to meet these objectives by working collaboratively at all levels of the service system. The Secretary appoints members to the CLTS Council to provide guidance to the DHS, the State Medicaid Agency, regarding waiver program policy and procedure decisions. DHS has established statewide CLTS Waiver Program policies and procedures which are disseminated to county waiver agencies and providers through

CATEGORY	DESCRIPTION
	and non-financial requirements, and reside in allowable living situations within the community. Allowable living situations within the community for participants include children who are living with their parents in the family's private residence, whether owned or rented. Allowable living situations also include participants who are living in the home of a relative or guardian, including foster care providers. For CLTS Waiver participants who are 18 years or older, an allowable living situation also includes an adult family home.
License/ Certification	LICENSURE TYPES DCF is responsible for licensing and monitoring foster care, kinship, group homes, residential care centers, shelter care and child placing agencies. There are three different ways to get licensed to be a foster parent in Wisconsin: through county, tribal or private agencies. Foster homes may be licensed for up to four children. A licensing agency may grant an exception to allow up to seven children in a Level 2 foster home only to accommodate a

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manuals, numbered memos, websites and webinars. In addition, ongoing technical assistance, monitoring and oversight activities for county waiver agencies are completed by DHS assigned Children's Services Specialists and other state Medicaid Agency staff.

DHS enters into contractual agreements with Wisconsin's county departments to act as the local agency responsible for operating the CLTS Waiver Program, which includes determining applicants' program eligibility, authorizing covered waiver supports and services, conducting annual recertification's and operating other long-term support programs that assist in meeting the needs of children and their families. These programs include early intervention services funded under the IDEA Part C and the state-funded Children's Community Options Program. The county waiver agency authorizes family-centered services and supports based on the assessed need of each child and his or her family to ensure continued health, safety, inclusion in the community and ability to reside in the least restrictive setting. With the submission of this CLTS Waiver Program renewal, new services have been added to the benefit package to ensure the supports and services available for children and their families meet the current challenges parents face in raising children with disabilities in today's environment.

As CLTS Waiver services are coordinated as the payer of last resort with services that are covered under the IDEA Part B Special Education Program through Wisconsin's Department of Public Instruction, and services covered under the Rehabilitation Act of 1973 through Wisconsin's Department of Workforce Development's Division of Rehabilitation, as well as coordination with the child's private health insurance, and economic support programs, as applicable. DHS monitors the county waiver agencies' compliance with the CLTS Waiver Program's payer of last resort and COB requirements through a comprehensive quality management and review system.

CATEGORY	DESCRIPTION
	sibling grouping. In order to exceed the limit of four children in a foster home, any additional child must be related to one of the initial four children placed in the home. Child Welfare Licenses are non-expiring but need to be continued every two years. STANDARD FOSTER CARE Also see certification requirements for Levels 3, 4 and 5. TREATMENT/THERAPEUTIC FOSTER CARE Also see certification requirements for Levels 3, 4 and 5.
Role of County/ Child Placing Agency	Child Placing Agencies are licensed by DCF to place children in foster and adoptive homes, as well as group homes. Child Placing Agencies may license their own foster homes. Also see Wisconsin Admin Code – Child Placing Agencies.
Provider Qualifications and Training *(Including Notable Curriculum Details If Available)*	STATE CHILDREN'S SERVICES AGENCY All foster parents are given a level of care certification during the foster care licensing process based on meeting qualifications, training, foster parent references and foster parent experience. There are five levels of care: each level of care certification has a specific number of training hours, personal references and experience requirements. Training is necessary to prepare foster parents and help them to continue to develop as a foster parent: • Level 3 applicants must submit three favorable references from non-related individuals and one favorable reference from a relative, preferably an adult child. Level 3 foster parents are also required to meet three of the prior experience requirements: A minimum of one year of experience as a foster parent or kinship care provider (with a child placed in the home for at least one year); a minimum of five years of experience working with or parenting children; a minimum of 500 hours of experience as a respite care provider; a high school diploma or the equivalent; a college, vocational, or technical advanced degree in an area related to a child's treatment needs such as nursing, medicine, social work, or psychology; a previous existing relationship with the child through professional or personal experience; or work or personal experience demonstrating the knowledge, skills, ability, and motivation to meet the needs of a child with a level of need of 3. • Level 4 applicants must submit three favorable references from non-related individuals and one favorable reference from a relative, preferably an adult child. Level 4 foster parents are also required to meet four of the prior experience requirements: a minimum of one year of experience with children who have a level of need of 3 as a foster parent or kinship care provider; a minimum of five years of experience working with or parenting children; a minimum of 500 hours of experience as a respite care provider; a

CATEGORY	DESCRIPTION
	high school diploma or equivalent; a college, vocational, or technical advanced degree in an area related to a child's treatment needs, such as nursing, medicine, social work, or psychology; a previous existing relationship with the child through professional or personal experience; work or personal experience demonstrating the knowledge, skills, ability, and motivation to meet the needs of a child with a level of need of 3. • Level 5 is considered exceptional treatment foster care, and is also sometimes referred to as "shift-staffed" foster care. These foster homes have staff members who work in rotating shifts to care for the children. Level 5 foster homes are generally created to meet the needs of specific children who need care into adulthood and the home becomes the adult resource. All Level 5 foster homes must receive prior approval from the DCF Exceptions Panel. **Foster Parent Training**[40] PRE-PLACEMENT / INITIAL / ONGOING Level 2: 6 / 36 / 36 + 4 child-specific Level 3: 30 / 24 / 24 +6 child-specific Level 4: 10 / 18 / 24

[40] Also see https://dcf.wisconsin.gov/fostercare/training and http://docs.legis.wisconsin.gov/code/admin_code/dcf/021_099/56/14

CATEGORY	DESCRIPTION
	MEDICAID Medicaid requirements cross reference to Children's Services Agency training requirements. **Individual — Individual Family Foster Provider:** (§48.62, Wisconsin Statutes, DCF 56, Administrative Code) All foster care providers must have specialized training related to the child's unique needs in order to effectively address the needs of each child served in a particular home and to ensure the child's health, safety and welfare. If these unique needs are generally related to emotional and behavioral needs, then the foster care provider must have training specific to the child's needs and specific psychiatric/behavioral treatment plan. If these unique needs are generally related to physical, medical and personal care the provider is responsible for implementing specific activities or treatments as outlined in a medical plan of care. **Agency — Level 5 Exceptional Foster Home:** (§48.62, Wisconsin Statutes, DCF 56, Administrative Code) All foster home providers must have specialized training related to the child's unique needs in order to effectively address the needs of each child served in a particular home and to ensure the child's health, safety and welfare. If these unique needs are generally related to emotional and behavioral needs, then the foster home provider must have training specific to the child's needs and specific psychiatric/behavioral treatment plan. If these unique needs are generally related to physical, medical and personal care the provider is responsible for implementing specific activities or treatments as outlined in a medical plan of care.
Evidence-Based Practices Used *(if applicable)*	No specific program model is identified at the state level. Foster Parent Training requirements, discussed below, are at https://dcf.wisconsin.gov/fostercare/training.
Required Interventions/ Program Elements	MEDICAID **Individual — Individual Family Foster Provider:** If the child's unique needs are generally related to physical, medical and personal care the provider is responsible for implementing specific activities or treatments as outlined in a medical plan of care. **Agency — Level 5 Exceptional Foster Home:** If child's unique needs are generally related to physical, medical and personal care the provider is responsible for implementing specific activities or treatments as outlined in a medical plan of care.

<table>
<tr><th>CATEGORY</th><th colspan="6">DESCRIPTION</th></tr>
<tr><td rowspan="3">Medicaid Delivery System[41]</td><td colspan="3">Delivery System for SMI/SED</td><td colspan="3">Delivery System for Foster Care</td></tr>
<tr><td colspan="2">☐ SED population in FFS system</td><td>☒ SED population enrolled in managed care</td><td colspan="2">☐ Foster care population in FFS system</td><td>☒ Foster care population enrolled in managed care</td></tr>
<tr><td colspan="2">☐ BH benefit managed FFS</td><td>☒ BH benefit managed by MCO or PIHP</td><td colspan="2">☐ BH benefit for children in foster care managed FFS</td><td>☒ BH benefit for children in foster care managed by MCO or PIHP</td></tr>
<tr><td>Financing Sources for TFC Services</td><td>☐ IV-E</td><td>☒ Medicaid Treatment (including TCM)</td><td>☒ Medicaid Administrative</td><td>☐ State General Fund</td><td>☐ County</td><td>☐ Other</td></tr>
<tr><td>Medicaid Provider of TFC Services (if applicable)</td><td>☒ State/ County Children’s Agency</td><td>☐ Child Placing Agency</td><td>☐ Foster Parent</td><td>☒ BH Services Organization/ Clinician</td><td>☐ Waiver Case Management Entity</td><td>☐ Not Applicable or Other</td></tr>
<tr><td>Payment Methods and Rates for TFC Services (if applicable)</td><td colspan="6">STATE CHILDREN’S SERVICES AGENCY
The Uniform Foster Care Rate (UFCR) is a standard scale of monthly payments to foster parents for the cost of caring for a foster child. Because the rate is based on the needs of each child, it may also include extra payments (called Supplemental and Exceptional Rate payments) in addition to a Basic Maintenance Rate.

There are four parts of the UFCR: Basic Maintenance Rate, Supplemental Rate, Exceptional Rate and Initial Clothing Allowance.

Within the first 30 days after a foster child is placed in a home, the foster parent and case worker will discuss whether the child may qualify for a Supplemental Rate payment. If the foster child has needs that require special care or supervision, the case worker will submit a description of the child's problems or characteristics. Evaluations from doctors,</td></tr>
</table>

[41] Children in foster care are enrolled in one of three managed care program types: Children Come First (CCF), Wraparound Milwaukee4Kids. CCF is a program that coordinates care for youth who have a mental health challenge and are at-risk of being placed in an institutional setting. In 2014, Wisconsin received federal approval of Care4Kids, a new Alternative Benefit Plan under 1937 authority, to operate a medical home to provide benefits to foster children entitled. Care4Kids provides benefits to qualifying foster kids via a non-risk PIHP. Children in the Foster Care Medical Home Program, receive BH treatment services, including autism treatment, from the PIHP. 1915(c) Medicaid HCBS waiver for the CLTS Waiver Program for children from birth through age 21 years.

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psychiatrists, therapists or other specialists may be included with the case worker's report.

Using a point scale and all of the information regarding the child's emotional, behavioral and medical needs, the placing agency determines the level of care the child requires and identifies special needs of the child. The level of care and the identified special needs of the child establish the Supplemental Rate.

The foster parent and case worker will review the foster child's progress at least every six months. At those reviews, the Supplemental Rate may be changed if the child's condition is changed.

No monthly payment for the combined Basic Maintenance Rate, Supplemental Rate and Exceptional Rate may be above $2,000.

If a child has extraordinary needs, the foster parent may receive an additional payment called an Exceptional Rate. This payment may be provided if the child's placement in a foster home allows the child to be released from a more restrictive setting or prevents the child's placement in such a setting. Only providers certified above a Level 1 can receive exceptional rates.

	JANUARY 2018		JANUARY 2019	
Certified Level One		$ 238		$ 244
Certified Above Level One (by Age)	0–4	$ 394	0–4	$ 404
	5–11	$ 431	5–11	$ 442
	12–14	$ 490	12–14	$ 502
	15–18	$ 511	15–18	$ 524

MEDICAID

Individual and Exceptional Foster Home services exclude the cost of room and board provided by the foster home provider. CLTS funding cannot supplant IV-E funding.

- This service may not duplicate any service that is provided under another waiver service category.
- Federal requirements prohibit the CLTS Waiver Program from funding any service that could be furnished under the EPSDT benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid or the Medicaid State Plan services. The CLTS Waiver Program is also the payer of last resort and coordination of benefits (COBs) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under Section 110,

CATEGORY	DESCRIPTION
	as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program, and FoodShare Wisconsin. Documentation must be maintained in the file of each CLTS Waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

APPENDIX C

ARIZONA FOSTER FAMILY TREATMENT ASSOCIATION (AZ-FFTA) INFORMANT INTERVIEW QUESTIONS

- It is our understanding that you put a packet of information together for AHCCCS which included an updated position paper and the FFTA best practices, uniform definition, and training proposal. Are you able to share this same packet of information with us and give us a high-level overview of what action has occurred as a result to date or what you would consider priority areas of focus?
- It is our understanding that medical necessity criteria and decision making is not experienced as consistent across the Regional Behavioral Health Authorities (RBHAs). One area we are analyzing is medical necessity for Home Care Training to Home Care Client (HCTC). Can you share in more detail, examples specific to HCTC decisions being made through the RBHAs' utilization review/utilization management units versus the Child and Family Team (CFT)?
  - It would be most helpful if you could share an example of when this goes smoothly as well as when there are barriers.
- How are HCTC providers included in the CFT process and service plan? Please describe how communication and data sharing occurs as part of this process.
  - Can you please provide examples on when this worked well as well as when there have been barriers?
  - How is discharge planning occurring between the CFT and HCTC provider?
  - Are their variances between RBHAs?
- Can you please share the current process and experience for becoming a licensed and trained HCTC provider? What is working? Where do barriers exist?
  - Are there any training tools or best practices out there or used in other states that FFTA is aware of?
- The HCTC Practice Tool was updated in 2016. Has this version of the tool been helpful in strengthening HCTC? Are there recommendations to improve upon this tool?
- It is our understanding that FFTA has recommended the need for state level policies and procedures. Can you please describe what you think would be needed in addition to what is comprised in the Practice Tool and your vision for how these documents would improve HCTC in Arizona?

APPENDIX D

REGIONAL BEHAVIORAL HEALTH AUTHORITY INTERVIEW PROTOCOLS

Introduction

The Arizona Health Care Cost Containment System (AHCCCS) has contracted with Mercer Government Human Services Consulting (Mercer) to conduct a review and independent analysis of Arizona's Therapeutic Foster Care (TFC)/Home Care Training to Home Care Client (HCTC) services provided to children and youth within and without the foster care system. Areas of interest include Utilization Management (UM) Practices, HCTC provider contracting and oversight, and the clinical model used by HCTC providers.

One component of the independent analysis is a review of materials provided by the Regional Behavioral Health Authorities (RBHAs) with a follow up interview with RBHA personnel who manage HCTC services and providers. The following questions are based on our review of the materials submitted by the RBHA. Thank you for taking the time for speaking with us.

CIC Questions

- Please describe your UM process. How did you develop the level of care (LOC) criteria/medical necessity criteria (MNC) guidelines? The prior authorization (PA) instructions state that HCTC is "never urgent or emergent" — please describe assumptions that support that assertion.
- How is UM related to Child and Family Team (CFT) activities? Care coordination activities, particularly with High Cost/High Need (HNHC) cases?
- Where is the service description in the HCTC provider contract? How do HCTC providers bill Cenpatico Integrated Care (CIC)? How is "session" defined? What activities are expected from the HCTC agencies (vs. the foster parents) and does the RBHA know or monitor how much the foster families are reimbursed for services?
- What kind of HCTC provider oversight activities does CIC conduct?
- Please describe the treatment model you expect your HCTC providers to implement. Any ongoing activities/monitoring that support fidelity to the treatment model? What kinds of training does the RBHA provide contracted HCTC agencies?
- Does CIC have any quality initiatives pertaining to HCTC providers or services? Please describe.

Health Choice Integrated Care (HCIC) Questions

- Please describe your UM process. Did you adopt or develop the LOC guidelines?
  - Follow up questions if not answered in the first response:

    - How are the general guidelines to CFT in the handbook used to determine appropriateness?
    - How are the clinical MNC used?
    - Who makes the clinical determination and what are their qualifications? (*Note: MNC in a document call "HCIC Clinical Guidelines for HCTC for Child/Adolescent Less Than 18 Years)*.
    - Per this document, case is referred to HCIC care management if in HCTC if youth stays in HCTC >6 months — what is the function of the HCIC care management?
- How is UM related to care coordination activities, particularly with HNHC cases?
- Please confirm that HCIC contracts with the HCTC providers, even though the home health (HH) manages UM activities.
  - Is there a service description in the contract — what is its source?
  - S5109 (HCTC) is listed as a "per session" by state; listed as "per diem" in handbook — please describe provider billing expectations (frequency, content).
  - What activities are expected from the HCTC agencies (vs. the foster parents) and does the RBHA know or monitor how much the foster families are reimbursed for services?
- What kind of provider oversight activities do HCIC conduct?
  - The handbook identifies some HCTC agency provider expectations (e.g., support the HCTC foster parents, monthly visit by an in-home consultant/family therapist, supervision requirements). How do you monitor the provider's compliance with these requirements? Are they in the provider's contracts?
  - What are the credentials of the in-home consultants/family therapists?
- Please describe the treatment model you expect your HCTC providers to implement. Any activities that support fidelity to the treatment model? What kinds of training does the RBHA provide contracted HCTC agencies?
- We noted you require a monthly HCTC capacity report from your HCTC providers — what do you do with this data?
- Does HCIC have any quality initiatives pertaining to HCTC providers or services? Please describe.

Mercy Maricopa Integrated Care (MMIC) Questions

- Please describe your UM process. How did you develop the LOC criteria/MNC guidelines? We noted that there are no discharge criteria — what was reasoning behind this?
- How is UM related/integrated to CFT activities? Care coordination activities, particularly with HNHC cases?

- What is the source of the service description in the HCTC provider contract?
  - How do HCTC providers bill MMIC? How is “session” defined?
  - What activities are expected from the HCTC agencies (vs. the foster parents) and does the RBHA know or monitor how much the foster families are reimbursed for services?
  - We noted in Section 2.3.15 of the Statement of Work, the requirement for telephonic/email and home visits. What is the expectation for these visits and who makes them?
- What kinds of HCTC provider oversight activities does MMIC conduct?
- Please describe the treatment model you expect your HCTC providers to implement. Any ongoing activities/monitoring that support fidelity to the treatment model? What kinds of training does the RBHA provide contracted HCTC agencies?
- Does MMIC have any quality initiatives pertaining to HCTC providers or services? Please describe.

UnitedHealthcare (UHC) Questions

- Please describe your UM process. How did you develop the LOC criteria/MNC guidelines?
- How is UM related/integrated to CFT activities? Care coordination activities, particularly with HNHC cases?
- Is there a service description in the provider contract?
  - How do HCTC providers bill?
    - We noted that S5109 HA is described as “per diem”. Is it expected that one unit of S5109 HA be billed every day? S5109 (HCTC) is listed as a “per session” by state; listed as “per diem” in UHC guideline — please describe provider billing expectations (frequency, content).
  - What activities are expected from the HCTC agencies (vs. the foster parents) and does the RBHA know or monitor how much the foster families are reimbursed for services?
- What kinds of HCTC provider oversight activities does UHC conduct?
- Please describe the treatment model you expect your HCTC providers to implement. Any ongoing activities/monitoring that support fidelity to the treatment model? What kinds of training does the RBHA provide contracted HCTC agencies?
- Does UHC have any quality initiatives pertaining to HCTC providers or services? Please describe.

MERCER (US) INC.
2325 East Camelback Road, Suite 600
Phoenix, AZ 85016
www.mercer.com