Table with Selected States' Coverage of Components of Wraparound Services and Therapeutic Foster Care

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Engagement of Child/Family	Arizona *Engagement of the child and family* is defined as the active development of establishing trust in the helping relationship based on personal attributes…The Child and Family Team (CFT) process is a partnership, and engagement is the beginning of that partnership. Examples of covered services that this activity may be billed under include: ▪ *Case management* which is a supportive service provided to enhance treatment goals and effectiveness and activities related to engaging the child/family such as brief telephone or face-to-face interactions with a person, family or other involved party for the purpose of maintaining or enhancing a person's functioning and participation in staffings, case conferences or other meetings with or without the person or his/her family participating. ▪ *Home care training family (family support)* which involves face-to-face interaction with 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 person in the home and community. Florida *Therapeutic behavioral on-site services* are designed to assist children who have complex needs and their families in an effort to prevent the need for more intensive, restrictive behavioral health placement. The process must be driven by assessment of the individual needs and strengths of each child and family and be developed and directed by a treatment team. The treatment team must include the child and family, informal support to the family system and the professionals	Arizona Division of Behavioral Health Services Covered Services Guide – July 2007 pp 78 and 87 Arizona Division of Behavioral Health Services Technical Assistance Document 3 – The Child and Family Team Process – Rev January 10, 2006 p 3 and Attachment 1 Florida Community BH services Coverage and Limitations Handbook for Medicaid: pp 2-1-34, 2-1-35 and 2-1-37

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	involved in providing services supports. The child-specific plan for therapeutic behavioral on-site services must be based on a thorough assessment, with input from the child and family regarding needs, strengths and desired outcomes of services…..It is recognized that involvement of the family in the treatment of the child or adolescent is necessary and appropriate. ▪ These services are intended to maintain the child in the home biological or foster. ▪ Services must be provided where the child is living, working or participating in education activities. ▪ Therapeutic behavioral on-site therapy includes – Assessment and engagement of the child or adolescent and family's natural support system to assist in implementation of the treatment plan. <u>Hawaii</u> Covered services include engagement of child/family as a component of the service: ▪ Under *intensive case management*, a requirement is to "establish and maintain a supportive relationship with the youth/family. Serve as a central point of contract for youth and family to the array of mental health services." ▪ The coordinated service plan must be built upon the strengths of the youth and family and developed with full engagement and involvement of youth, family/guardian and key individuals involved in the youth's life. ▪ Under *functional family therapy* one of its service goals is the "engagement of all family members and motivation of the youth and family to develop a shared family focus to the presenting programs." <u>Nevada</u>	Hawaii – Interagency Performance Standards and Practice Guidelines – Purple Book pp 149, 10 and 266

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	Family involvement which is defined as active input, guidance and participation in treatment planning, implementation and follow-up, must be documented on the treatment plan when there is a legally responsible adult for a child or recipient identifies a family member as anyone being integral to their mental health stabilization. <u>Nebraska</u> For *outpatient mental health and substance abuse services*, the manual states that NMAP will pay for conferences with family or other representatives, advising them on how to assist the client when the service is reasonably expected to improve the client's condition. Conferences may include the client's department case manager, school staff members, probation officers etc…. <u>Oregon</u> Under the rules for Children's Intensive Mental Health Treatment Services (ICTS): ▪ Providers must: 1) be able to demonstrate family involvement and participation in all phases of assessment, service planning and the child's treatment by documentation in the clinical record, and 2) have a policy on family involvement that includes specific supports to family members that address and prevent barriers to family involvement. ▪ Maintain a formal relationship with a family organization for the purpose of assuring that family voice is part of all decision making and planning for the development of services, quality assurance, and use of resources. ▪ Providers must ensure that a *child family team* is identified and organized jointly with the family, a child family team meeting is convened and an initial service coordination plan is developed.	Nevada Medicaid Services Manual – Chapter 400 – p 4 Nebraska HHS Finance and Support Manual Chapter 471 NAC 32-002.10F Oregon – Standards for Children's Intensive Community-Based Treatment and Support Services – 309-032-1250(6)-(7) and 1260

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	Rhode Island In the Children's Intensive Services (CIS) standards, engagement of the child and family is stressed throughout. Examples include: ▪ A critical objective of CIS is for parents to be able to safely and satisfactorily address their child's behaviors and functioning while living at home. Children and parents are to actively work with the provider in the shaping, development and implementation of the Service Plan. This child/family/provider working partnership must be clearly evident in all Treatment Plan documentation. (see section 4.8) ▪ CIS provider-agencies must incorporate key components of family-centered care into their philosophy, service program, operations and education. One resource to refer to is "Family - Centered Practice: How are we doing?" There are many more resources available for review by potential providers. Applicants must demonstrate the manner in which important principles of family-centered care are part of their approach to services. The provider must ensure the greatest degree of family participation in the full range of CIS activity. (see section 5.3) The CEDARR program is family focused; seeking to incorporate the key elements of family centered community based care into practice. The PASS program is a consumer-directed approach that assumes the family wants to and is able to take on the primary responsibility of identifying and prioritizing service goals and objects. Uses a family – professional team with family describing what should be done and PASS staff describing how it should be done.	Rhode Island – Standards for Providers of Children's Intensive Services: September 1, 2003 pp 24-27 Rhode Island – Certification Standards for CEDARR Family Centers: May 25, 2000 pp 1-4 Rhode Island – Certification Standards Personal Assistance Services and Supports: September 27, 2004 pp 6-7

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Immediate Crisis Stabilization	<u>Georgia</u> *Crisis intervention* is a covered service that is directed toward the support of a child who is experiencing an abrupt and substantial change in behavior which is usually associated with a precipitating situation and which is in the direction of severe impairment of functioning or a marked increase in personal distress. It is designed to prevent out of home placement or hospitalization. Examples given of interventions that may be used to de-escalate a crisis situation include: a situational assessment; active listening and empathic responses to help relieve emotional distress; effective verbal and behavioral responses to warning signs of crisis related behavior; assistance to, and involvement/participation of the individual (to the extent he or she is capable) in active problem solving planning and interventions; and facilitation of access to a myriad of crisis stabilization and other services deemed necessary to effectively manage the crisis. Crisis assessment and intervention is also covered as a component of other covered services such as *community support – team, crisis stabilization program services and intensive family intervention.* <u>Hawaii</u> Four types of emergency behavioral health services are covered (i.e., crisis stabilization) ▪ *24-hour crisis telephone stabilization* which via telephone provides initial assessment, support, consultation and referral to dissipate the crisis situation. ▪ *Crisis mobile outreach* which include services such as crisis intervention and counseling, intensive in-home services to stabilize family. The immediate response involves conducting an assessment of risk, mental status, and medical stability and immediate crisis resolution/stabilization and de-	Georgia Provider Manual Part I, Section 1 for Mental Health and Addictive Services July 2006 - Core Benefit Package pp 8-10, 53-58, 64-67 and 68-72 Hawaii – Interagency Performance Standards and Practice Guidelines – Purple Book pp 47-65; 153, 159 and 182

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	escalation. ▪ *Crisis therapeutic foster home* which provides acute intervention to youth who are experiencing a period of acute stress that impairs their capacity to cope with normal life circumstances and who cannot be safely managed in a less restrictive setting. ▪ *Community-based crisis group home* which provides short-term, acute residential interventions, including crisis intervention stabilization, counseling, family-based interventions, psychiatric evaluation and medication management, skills developments and services to assist in securing necessary community supports. Crisis management is also a service component of *intensive in-home intervention*, *multi-systemic therapy*, and *multidimensional treatment therapy* <u>Kentucky</u> *Crisis stabilization* is a covered service under the Impact Plus program and includes comprehensive assessment, diagnosis and treatment and a discharge plan to link the child with community services and supports. <u>North Carolina</u> *Mobile crisis management* involves all support, services and treatments necessary to provide integrated crisis response, crisis stabilization interventions and crisis prevention activities. Crisis response provides an immediate evaluation, triage and access to acute mental health, developmental disabilities, an/or substance abuse services, treatment and supports to effect symptom reduction, harm reduction and/or to safely transition persons in acute crises to appropriate crisis stabilization and detoxification supports/services.	Kentucky 907 KAR 3:030. Coverage and payment for IMPACT Plus services North Carolina, Division Of Medical Assistance – Enhances Mental Health and Substance Abuse Services Manual p 34

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	<u>Rhode Island</u> *Crisis stabilization and 24 hour crisis assessment/intervention* (a covered service under CIS) is described as follows: ▪ This service will consist of a response to an emergency or crisis, which is characterized by sudden onset, rapid deterioration of cognition, judgment, or behavior, is time limited in intensity and duration, and poses serious risk of harm to the individual or others. ▪ Crisis management plans should include measurable goals and objectives geared toward moving the child to the next level of care. Attachment A notes that an admission criteria for Level I care (crisis management/stabilization) under CIS is a crisis that requires behavioral health intervention and assessment to ensure safety of child/family.	Rhode Island – Standards for Providers of Children's Intensive Services: September 1, 2003 p 20
	<u>Oregon</u> A service component under the rules for Children's Intensive Mental Health Treatment Services (ICTS) is *crisis prevention and intervention* (also referred to as children's crisis service) and includes: ▪ 24 hours, seven days per week face-to-face or telephone screening to determine the need for immediate services for any child requesting assistance or for whom assistance is requested; ▪ 24 hours, seven days per week capability to conduct, by or under the supervision of a QMHP, a mental health status examination to determine the child's condition and the interventions necessary to stabilize the child; ▪ Provision of medically appropriate child and family, psychological, and psychiatric services necessary to stabilize the child;	Oregon – Standards for Children's Intensive Community-Based Treatment and Support Services – 309-032-1265(1)

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	▪ Referral to the appropriate level of care and linkage to other medically appropriate interventions necessary to protect and stabilize the child; and ▪ Linkage to appropriate social services. <u>South Carolina</u> ▪ *Mental health services not otherwise specified* includes crisis management. Services are designed to defuse a crisis that threatens the child's stability within the home environment. The child, family members, and other key individuals in the child's environment learn to evaluate the nature of the crisis as well as to anticipate and defuse crises and thus reduce the likelihood of recurrence. ▪ *Psychosocial rehabilitative services* includes as a component crisis management which is provided immediately to the identified child following abrupt or substantial changes in the child's functioning. Employed to reduce the immediate personal distress, assess the precipitant(s) that resulted in the crisis and/or to reduce the change of future crisis situations.	South Carolina Medicaid Children's Behavioral Health Services Provider Manual pp 2-30, 2-31, and 2-72
Ongoing Crisis and Safety Planning	<u>Georgia</u> Two of Georgia's core services for children include safety planning: ▪ *Community support (individual)* includes in the list of activities: Planning in a proactive manner to assist the child/youth and family in managing or preventing crisis situations. ▪ *Diagnostic assessment and individualized resiliency planning* requires that concurrent with individualized resiliency plan an individualized safety plan should also be developed with individual child, parent or caregiver.	Georgia Provider Manual Part I, Section 1 Mental Health and Addictive Service Definition and Guidelines: Core Benefit Package - pp 2 and 12

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	Hawaii Each service plan includes a proactive crisis plan reflective of strategies to avert potential crises, ensure safety using specific and appropriate strategies already known to staff for implementation to manage situations without placement disruptions. In the event a student/youth's behavior is deemed to be a risk to self or others, the school or contracted agency's clinical professional staff must be involved in assessment and determination of appropriate courses of actions. Crisis plans that include natural consequences (e.g., police involvement) should define the positive behavioral supports that should be implemented and exhausted prior to police involvement. Crisis planning is part of the mental health treatment plan developed by the service provider and must be tailored to the individual's known or potential high-risk situations that specifically address setting events, triggers, preventive as well as reactive interventions is an expected component of the MHTP that build off the crisis component in the CSP. The crisis plan components will address problematic behaviors utilizing the known strengths and preferences of the youth to reduce or eliminate the high-risk situations and assure youth's safety. Providers of *crisis therapeutic foster home* and *community-based crisis group hom*e are required to develop a crisis plan if one does not exist for the child. *Individual therapy, functional family therapy* and *treatment service planning participation* include crisis planning as a component of the service. Kentucky Requires the Impact Plus care plan to include a crisis action plan that progresses through a continuum of care that begins with the use of natural supports and	Hawaii – Interagency Performance Standards and Practice Guidelines – Purple Book pp 8, 11, 251, and 274 Kentucky 907 KAR 3:030. Coverage and payment for IMPACT Plus services

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	progresses through low to high intensity services or inpatient services (i.e., strategies to manage the crisis). Also the care plan asks for a description of symptoms or behaviors that indicate a crisis. <u>New Mexico</u> *Community support service* activities include: 1) assistance to individual (SED children) in development and coordination of the individual's service plan including a recovery/resiliency management plan, crisis management plan…and 2) assessment, support and intervention in crisis situations including the development and use of crisis plans which recognize the early signs of crisis/relapse, use of natural supports, use of alternatives to ED and inpatient services. <u>North Carolina</u> *Mobile crisis management* involves all support, services and treatments necessary to provide integrated crisis response, crisis stabilization interventions, and crisis prevention activities. *Mobile crisis management* also includes crisis prevention and supports that are designed to reduce the incidence of recurring crises. Crisis supports and services are to be specified in a recipient's crisis plan which is a component of the person centered plan. All person centered plans are required to include a crisis plan and at transition plan. <u>Oregon</u> Under the rules for Children's Intensive Mental Health Treatment Services	(also see example of care plan on the web) New Mexico Interagency Behavioral Health Service Requirements and Utilization Guidelines – Comprehensive Community Support Services North Carolina Enhanced Mental Health and Substance Abuse Services Manual pp 34 and 73 Oregon – Standards for Children's

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	(ICTS): ▪ The providers must ensure that as part of the service coordination plan, which is developed by a child and family team, there is a proactive safety/crisis plan that utilizes professional and natural supports to provide 24 hours, seven days per week flexible response and is reflective of strategies to avert potential crises without placement disruptions and provide appropriate interventions when crises occur. ▪ *Case management* includes providing crisis planning, prevention and intervention services. ▪ *Care coordination* includes facilitating and participating in team meetings at which strengths and needs are identified and safety planning occurs. <u>Rhode Island</u> *Crisis stabilization and 24 hour crisis assessment/intervention* (a covered service under CIS) is described as follows: ▪ This service will consist of a response to an emergency or crisis, which is characterized by sudden onset, rapid deterioration of cognition, judgment, or behavior, is time limited in intensity and duration, and poses serious risk of harm to the individual or others. ▪ Crisis management plans should include measurable goals and objectives geared toward moving the child to the next level of care. Attachment A notes that an admission criteria for Level I care (crisis management/stabilization) under CIS is a crisis that requires behavioral health intervention and assessment to ensure safety of child/family. Under Personal Assistance Services and Supports (PASS), a component of the service plan (see below) is safety arrangements that includes identification of	Intensive Community-Based Treatment and Support Services – 309-032-1245(3) and (4) and 1260 Rhode Island – Standards for Providers of Children's Intensive Services: September 1, 2003 p 20 Rhode Island – Certification Standards Personal Assistance Services and

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	safety risks and issues in provision of direct services, documentation of child-specific training to minimize and manage untoward events, general safety procedures, incidence reporting and direct services back up plan.	Supports: September 27, 2004 pp37
Strengths/Needs Assessment	Arizona *Assessment, evaluation and screening services* are covered services that involve the gathering and assessment of historical and current information which includes face-to-face contact with the person and/or the person's family or other informants, or group of persons resulting in a written summary report and recommendations. Arizona uses a standardized assessment that includes gathering information from the person and family/significant others regarding their special needs, strengths and preferences. As part of the clinical formulation/case summary, the assessor is required to identify strengths and needs of the person and his/family and to summarize on the service plan the person/family strengths that have been identified through the assessment process and to draw upon these strengths in developing the interventions to meet the person's specific service plan objectives. Florida *Therapeutic behavioral on-site services* are designed to assist children who have complex needs and their families in an effort to prevent the need for more intensive, restrictive behavioral health placement. The process must be driven by assessment of the individual needs and strengths of each child and family and be developed and directed by a treatment team. ▪ *Therapeutic behavioral on-site therapy services* include…strength-based clinical assessment of the mental health, substance abuse or behavioral	Arizona Division of Behavioral Health Services Covered Services Guide – July 2007 – p 34 Arizona Instruction Guide for the Assessment, Service Plan and Annual Update – 1/1/2006 – pp 1, 31-32, 64 Florida Community BH services Coverage and Limitations Handbook for Medicaid pp 2-1-34 and 2-1-37

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	healthy disorders… <u>Georgia</u> *Diagnostic assessment and individualized resiliency planning* is a covered service that includes performing a formalized assessment in order to determine the individual's problems, strengths, needs, abilities and preferences, to develop a social (extent of natural supports and community integration) and medical history, to determine functional level and degree of ability versus disability, and to develop or review collateral assessment information. *Community support team* which is a resiliency oriented, intensive, community-based service has as a service component individualized interventions, which may include identification, with the child/youth, of strengths which may aid him or her in enhancing resilience, as well as barriers that impede the development of skills necessary for age-appropriate functioning in school, with peers, and with family. <u>Hawaii</u> Covers a number of different types of assessments including but not limited to: ▪ *Comprehensive Mental Health Assessment*, used to determine eligibility for the program is a strength-based approach used to identify the needs of the youth/young adult in the context of their family and community. This includes reviewing documentation, interviewing family members, interviewing child and obtaining collateral information (teacher, therapist). ▪ *Focused Mental Health Assessment*, is an in-depth evaluation to clarify diagnostic and treatment issues when new clinical symptoms have emerged or when there is a lack of progress. Builds upon previous evaluations.	Georgia Provider Manual Part I, Section 1 for Mental Health and Addictive Services July 2006 - Core Benefit Package pp 11-14 and 53-58 Hawaii – Interagency Performance Standards and Practice Guidelines – Purple Book pp 232, 236, and 145

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	Kentucky The Impact Plus care plan includes a section entitled *strengths assessment* that provides a description of the child strengths, family strengths and natural supports. Oregon Under the rules for Children's Intensive Mental Health Treatment Services (ICTS): ▪ *Care Coordination* includes facilitating and participating in team meetings at which strengths and needs are identified and safety planning occurs. ▪ *Case Management* includes identifying strengths and needs. ▪ The goals of the service planning process are to build on child and family strengths in providing services that are directed toward successful home, school, and community functioning. ▪ The service coordination plan must include a strengths and needs assessment that includes all relevant domains of the comprehensive mental health assessment. Rhode Island *Development of a detailed individual treatment plan* (a covered service under CIS) is described as follows: ▪ Based on measurable and specific goals. The plan will be based on the comprehensive assessment of child and family strengths and needs; and will include a continuum of services and will be updated as per the utilization management process included in the levels of care standards; an integral part of the individualized treatment plan and assessment includes intimate	Impact Plus program web site. Oregon – Standards for Children's Intensive Community-Based Treatment and Support Services 309-032-1240, 1245(3) and (4), 1260(3) Rhode Island – Standards for Providers of Children's Intensive Services: September 1, 2003 pp 29-30

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	coordination with other appropriate agencies, family/ community resources in order to maximize the service benefit for the child and family. ▪ Specific components of the assessment include: - Caregivers' understanding of child's strengths and their needs and difficulties in meeting those needs; - Current stressors on child and family and supports available to them which may be gathered through conversations with the child, other family members and involved professional collateral contacts; - Family's ability and willingness to engage in proposed treatment; - Strengths and difficulties in child and family's interaction with the larger environment (e.g. school, legal system, peer groups); - The availability and effectiveness of other service providers, systems of care and payers in supporting the child and family in treatment; Under CEDARR the provider performs an *initial family assessment* that includes looking at family circumstances, strengths, needs and supports. Kids Connect covers *therapeutic integration assessment and plan development* that includes review of information gathered by CEDARR centers and consideration of child's ability in variety of areas. PASS covers *assessment and service plan development* that includes, by working with the child's family, the identification of the strengths, capacities, preferences, needs and desired outcomes of the individualized services and supports. <u>South Carolina</u> The description of assessment and treatment planning for *individual community*	Rhode Island – Certification Standards fro CEDARR Family Centers: May 25, 2000 pp 20-21 Rhode Island – Certification Standards Therapeutic Child and Youth Care: April 15, 2003 pp 22-23 Rhode Island – Certification Standards Personal Assistance Services and Supports: September 27, 2004 pp 33-37 South Carolina Children's Behavioral

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	based services includes: ▪ An individual treatment plan that must be developed mutually by the identified child and/or the family along with the Lead Clinical staff after a thorough assessment of the child and family's strengths and needs and in collaboration with the referring agency's case manager. ▪ *Psychosocial rehabilitation services* that includes as a component of assessment and evaluation which is defined as follows: Behavioral, emotion, and environmental assessment and evaluation services provide a determination of the nature of the child's and/or family's problems, factors contributing to the problems, and the strengths and resources of the client and family.	Health Services Provider Manual pp 2-40 and 2-71
Wraparound Team Formation	<u>Arizona</u> Arizona's expectations for application of the child and family team process with every Title XIX/XXI eligible child includes *child family team formation* which the size, scope and intensity of involvement of the team members are driven by the objectives established for the child, reflecting those individuals needed to develop and coordinate an effective service plan. Examples of covered services that this activity may be billed under include: ▪ *Case management* which is a supportive service provided to enhance treatment goals and effectiveness and activities related to engaging the child/family such as brief telephone or face-to-face interactions with a person, family or other involved party for the purpose of maintaining or enhancing a person's functioning and participation in staffings, case conferences or other meetings with or without the person or his/her family participating. ▪ *Home care training family (family support)* which involves face-to-face	Arizona Division of Behavioral Health Services Covered Services Guide – July 2007 pp 78 and 87 Arizona division of Behavioral Health services Technical Assistance Document 3 – The Child and Family Team Process – Rev January 10, 2006 p 6 and Attachment 1

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	interaction with 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 person in the home and community. <u>Hawaii</u> The service description for *intensive case management* states that "The process of case management is accomplished largely through relationships. A therapeutic alliance between the Mental Health Care Coordinator (MHCC) and the youth and family is vital for maximizing the positive outcomes of case management and service provision interventions. Collaborative relationships with other professionals to accomplish coordinated assessment, evaluation, joint planning and decision-making, adherence to established Interagency Performance Standards and Practice Guidelines (IPSPG), and implementation of evidenced-based practices are essential." As such the MHCC is required to: 1) establish and maintain a supportive relationship with the youth/family; 2) conduct face-to-face and telephone contacts with the youth/family and collateral professionals; and 3) convene a coordinated service plan meeting within 30 days of youth's eligibility determination. <u>Kentucky</u> Impact Plus program requires: ▪ Development of a comprehensive collaborative plan by a team in a face-to-face meeting. Members of the team include parent, guardian or caregiver, clinical professionals, provider of targeted case management (TCM) and other adults recommended by the parent, guardian or caregiver who have knowledge or special expertise regarding the child and are willing to participate.	Hawaii – Interagency Performance Standards and Practice Guidelines – Purple Book pp 10 and 149 Kentucky 907 KAR 3:030. Coverage and payment for IMPACT Plus services

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	▪ As an activity of TCM the coordination of collaborative team meetings to develop, review and modify a collaborative service plan. In addition, the program covers *collateral services* which is a behavioral health consultation or service planning meeting with a parent, legal representative, school personnel or other persons with custodial control or supervision of the eligible child. <u>Nevada</u> The state requires the family's active input, guidance and participation in treatment planning, implementation, monitoring, and follow up. Family involvement must be documented on the treatment plan anytime there is a legally responsible adult for a child and when a recipient identifies a family member as being integral to their mental health stabilization. *Child and family team* is defined as a family-driven, child-centered, collaborative service team, focusing on the strengths and needs of the child and family. The team consists of the child, parents, service professionals and may also consist of family members, care providers, and other individuals identified as being integral to the child's environment or mental health rehabilitation. <u>North Carolina</u> As part of the person-centered planning process, the state notes that it is important to include people who are important in the person's life such as family, legal guardian, professionals, friends and others as identified by the individual (i.e., employers, teachers, faith leaders, etc.). This individuals can be essential to the planning process and help drive its success.	Nevada Medicaid Services Manual – Chapter 400 – 402.6 pp 2 and 4 North Carolina, Enhanced Mental Health and Substance Abuse Services Manual pp 6, 69 and 70

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	Day treatment provides case management services that includes…convening Child and Family Team meetings to coordinate the provision of multiple services and ensure appropriate modification of the personal care plan over time. Child and family team are those persons relevant to the child's successful achievement of services goals including, but not limited to family members, mentors, school personnel and members of the community who may provide support, structure and services to the child. (Children may be residents of their own home or a substitute home with day treatment provided in setting separate from the consumer's residence.) <u>Oregon</u> Under the rules for Children's Intensive Mental Health Treatment Services (ICTS): ▪ Providers must ensure that a *child family team* is identified and organized jointly with the family, a child family team meeting is convened and an initial service coordination plan is developed. ▪ *Child family team* is defined as those individuals who are responsible for creating, implementing, reviewing, and revising a service coordination plan. At minimum the team must be comprised of the family, care coordinator, and child when appropriate. The team should also include any involved child-serving providers and agencies and any other natural, formal, and informal supports as identified by the family. ▪ *Care coordination* which is a service component of intensive community-based treatment and support is the process oriented activity that provides ongoing communication and collaboration with children and families with multiple needs. Care coordination includes: facilitating communication between the family, natural supports, community resources, and involved child-serving providers and agencies; organizing, facilitating and	Oregon – Standards for Children's Intensive Community-Based Treatment and Support Services – 309-032-1245(3) and (6) and 1260

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	participating in team meetings at which strengths and needs are identified and safety planning occurs; and providing for continuity of care by creating linkages to and managing transitions between levels of care and transitions for older youth to the adult service system.	
Wraparound Service Plan Development	Florida *Treatment plan* is defined as a structured, goal-oriented schedule of services developed jointly by the recipient and the treatment team (Note: for *therapeutic behavioral on-site services*, the treatment team includes the child, family, other person who provide informal supports and professionals). The plan must include: ▪ Goals appropriate to diagnosis, age, culture, strengths, abilities, preferences and needs expressed by recipient ▪ Measurable objectives and target dates ▪ List of services and amount, frequency and duration ▪ Transition or discontinuation of services Georgia *Diagnostic assessment and individualized resiliency planning* includes the development of an individualized recover/resiliency plan (IRP). Providers are required to use information from the diagnostic assessment to develop, together with the child and caretakers and IRP that support resilience and that is based on goals identified by the individual with parent(s)/responsible caregiver(s) involvement. The cornerstone component of the child and adolescent diagnostic assessment and resulting IRP involves a discussion with the child/adolescent and parent(s)/responsible caregiver(s) regarding what resiliency means to them personally, and the development of goals (i.e. outcomes) and objectives that are	Florida Community BH services Coverage and Limitations Handbook for Medicaid – pp 2-1-15 and 2-1-34 Georgia Provider Manual Part I, Section 1 for Mental Health and Addictive Services July 2006 - Core Benefit Package pp 11-13

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	defined by and meaningful to the child/adolescent based upon the individual's articulation of their recovery hopes. Concurrent with the development of the IRP, an individualized safety plan is also to be developed, with the individual child and parent(s)/responsible caregiver(s) guiding these process through the free expression of their wishes and through their assessment of the components developed for the safety plan as being realistic for them. <u>Hawaii</u> For eligible children, two linked service plans are developed: ▪ *Coordinated Service Plan (CSP)* The CSP builds upon the strengths of the youth and family and is developed with full engagement and involvement of youth, family/guardian, and key individuals involved in the youth's life including existing or potential service providers. The CSP uses resources available through the service system and those naturally occurring in the youth's family and community. By definition it includes full participation of schools and other public agencies. CSP planning is guided by a long-term holistic view of the youth's life. The purpose of the CSP is to identify the specific strategies that will achieve broadly defined goals for the youth and family, and to integrate strategies across all those involved. ▪ *Mental Health Treatment Plan (MHTP)* The development, implementation, review, revision and adjustments to the MHTP are the responsibility of the service provider. MHTP is individualized for each youth and is an ongoing collaborative process driven by the family/guardian and youth that includes the contractor, family and the mental health care coordinator (MHCC). MHTPs must be directly linked to achieving goals in a youth's IEP and/or CSP. They are to identify evidence-based treatment interventions that are the most promising options for delivering positive treatment outcomes for a youth's individual goals and objectives.	Hawaii – Interagency Performance Standards and Practice Guidelines – Purple Book pp 10, 149, and 274

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	In addition *to intensive care management, treatment/service planning participation* is a covered service and involves the development, review, and modification of a MHTP, CSP, crisis plan, discharge/transition plan, and other interagency treatment/service plans when specifically requested by the MHCC and is provided by a CAMHD Clinician This service includes: 1) attendance and active participation at a multi-disciplinary treatment/service planning conference; 2) provision of an organized presentation of pertinent information related to mental health issues; and 3) participation in the formulation of plans for mental health services, including but not limited to the identification of goals, measurable objectives, and interventions based on young adult or youth/family needs. <u>Kentucky</u> The Impact Plus care plan must specify modality, frequency, intensity and duration of services, who will manage the continuity of care, interventions by caregivers, problems with intervention and objective measurable goals, discharge criteria, crisis action plan, and plan for transition. <u>Nevada</u> *Treatment plan* is defined as a written individualized plan developed jointly with the recipient and/or their legal representative, qualified mental health professional or associate or treatment home provider and in collaboration with the family, when appropriate and whenever possible. The treatment plan must be based on comprehensive assessment and include: 1) strengths and needs of the recipient and his/her families; 2) intensity of needs determination; 3) measurable goals and objective; 4) specific treatment, services and interventions including	Kentucky 907 KAR 3:030. Coverage and payment for IMPACT Plus services (also copy of the actual plan format is on the web) Nevada Medicaid Services Manual – Chapter 400 p 9

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	amount, scope, duration and provider of services; 5) discharge criteria specific to each goal, and 6) for high risk recipients accessing services from multiple government-affiliated or private agencies, evidence of care coordination by those involved with the recipient's care. <u>North Carolina</u> In order to bill a service to Medicaid, a written person-centered plan for the delivery of medically necessary services must be in place. Person-centered planning is a process of determining real-life outcomes with individuals and developing strategies to achieve those outcomes. The process supports strengths and recovery and applies to everyone supported and served in the system. For all individuals receiving services, it is important to include people who are important in the person's life such as family, legal guardian, professionals, friends and others as identified by the individual (i.e., employers, teachers, faith leaders, etc.) <u>Oregon</u> Under the rules for Children's Intensive Mental Health Treatment Services (ICTS) two linked plans are developed: ▪ *Service coordination plan* which is a written summary document that incorporates and supports the relevant plans, services, and supports that are being provided to the child and family by the providers, agencies, and others who comprise the child and family team as well as defining roles and responsibilities of each party. The service coordination plan is formulated by the team and approved by the family. Specific required components of this plan include: a strengths and needs assessment, short and long term goals, service planning with documentation of who is responsible for	North Carolina, Enhanced Mental Health and Substance Abuse Services Manual p 6 Oregon – Standards for Children's Intensive Community-Based Treatment and Support Services – 309-032-1245(37) and (40) and 1260

Wraparound Services Components	Other States' Covered Medicaid Behavioral Health Services	Source
	providing the informal and formal services, safety/crisis plan, and discharge criteria and transition planning. ▪ *Treatment plan* which is the written plan developed jointly by the QMHP and the child with his or her family, if appropriate. The treatment plan specifies the DSM diagnosis, goals, measurable objectives, specific treatment modalities and evidence-based practices. It is based on a completed comprehensive mental health assessment or assessment update of the child's functioning and the acuity and severity of psychiatric symptoms. <u>Rhode Island</u> In the CIS standards, examples of requirements for the treatment plan include specific proposals in regard to: ▪ Treatment/service goals and objectives, which are measurable, observable, specific and time limited-, as appropriate to the child and family/care giver-designed to enhance the child's and family's functioning within the family/caretaker environment and the larger community; ▪ Coordination with and participation of the family; ▪ Team structure and delineation of the role of each member of the treatment and supervisory structure Under CEDARR, development of a *family care plan* is a distinct service. The plan is to be developed with the family and child as appropriate, be individualized, identify and build on strengths, identified goals and objectives. Kids Connect covers *therapeutic integration assessment and plan development* that includes development of plan with measurable goals and objectives and is based on child's strengths to overcome the specific barriers to participation identified in the assessment.	Rhode Island – Standards for Providers of Children's Intensive Services: September 1, 2003 pp 30-31 Rhode Island – Certification Standards fro CEDARR Family Centers: May 25, 2000 pp 24-25 Rhode Island – Certification Standards Therapeutic Child and Youth Care: April 15, 2003 P23-24

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	PASS covers *assessment and service plan development* that includes in the service plan goals and objectives, intensity, duration and services schedule, roles and responsibilities, implementation steps and timeframes and safety arrangements.	Rhode Island – Certification Standards Personal Assistance Services and Supports: September 27, 2004 pp 33-37
Wraparound Services Plan Implementation	<u>Natural Supports</u>: ▪ FL: Requires that for therapeutic behavioral on-site services the treatment team include…other persons who provide natural, informal support to the family system and professionals involved in providing services and that the services includes the assessment and engagement of the child/adolescent and family's natural support system to assist in implementation of the treatment plan. (pp 2-1-34 and 37) ▪ GA: service activities under *community support –individual* include support to facilitate enhanced natural and age-appropriate supports and encouraging the development and eventual succession of natural supports in school and other social environments. ▪ KY: Impact Plus care plan requires identification of natural supports. (web) ▪ NC: Person center planning uses a blend of paid and unpaid, natural and public specialty resources uniquely tailored to the individual/family needs and desires. It is important for the person-centered planning process to explore and utilize both. (p 6) ▪ OR: Requires that service planning utilize a combination of existing or modified formal services, newly created services, informal, formal and natural supports and community resources. (309-032-1260) ▪ RI: Under CEDARR, the standards state that one of the core practices of family centered care is ensuring services that enable smooth transitions	The page numbers by each state refer to the following sources: Arizona (AZ) ▪ Arizona Division of Behavioral Health Services Covered Services Guide – April 2007 Florida (FL) ▪ Florida Community Behavioral Health Services Coverage and Limitations Handbook for Medicaid - 10/04 Georgia (GA) ▪ Provider Manual Part I, Section 1 for Mental Health and Addictive Services July 2006 - Core Benefit Package Kentucky (KY) ▪ Impact Plus website (care plan)

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	among service systems and natural supports which are appropriate to developmental stages of the child and family. (p 4) <u>Formal Supports</u>: Under PASS Rhode Island specifically reimburses for a service called *service plan implementation* which includes promotion of continuity of care and long-term retention of direct service workers and ensure the quality and content of the direct services. (see pp 39-41 of PASS standard) Diagnostic intellectual evaluations ▪ AZ: psychological testing (CPT 96101-03) (pp 34-35) ▪ FL: psychological testing (p 2-1-6) ▪ GA: psychological testing (p 11) ▪ NV: psychological testing which includes evaluation of intellectual functioning (p 8) ▪ NC: billed using appropriate CPT codes (p 40) Comprehensive neurological evaluations: ▪ AZ: : neuropsychological testing (CPT 96116-119) and neurobehavioral testing (CPT 96120) (p 35) ▪ NV: neuropsychological testing and neurobehavioral testing (p 8) ▪ NC: billed using appropriate CPT codes (p 40) Therapeutic behavioral support services ▪ FL: therapeutic behavioral on-site therapeutic support services (p 2-1-41) ▪ NV: basic living skills, day treatment, psychosocial rehabilitation (pp 15-17) ▪ RI: under CIS – intensive therapeutic treatment (p 21)	▪ Kentucky 907 KAR 3:030. Coverage and payment for IMPACT Plus services Nevada (NV) ▪ Nevada Medicaid Services Manual: Chapter 400 – Behavioral Health (3/2007) North Carolina (NC) ▪ North Carolina Division of Medical Assistance – Outpatient Behavioral Health Manual – 6/1/2007 Oregon (OR) ▪ Standards for Children's Intensive Community-Based Treatment and Support Services – 309-032-1260 ▪ Oregon Health Plan Mental Health: Medicaid Procedure Codes and Reimbursement Rates for Services Provided On or After 7/1/07 Rhode Island (RI) ▪ Certification Standards fro CEDARR Family Centers: May 25, 2000. ▪ Rhode Island – Standards for Providers of Children's Intensive Services: September 1, 2003

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	Individual and family crisis planning and intervention services ▪ AZ: crisis intervention (pp 119-128) ▪ GA: crisis intervention, crisis stabilization program services (pp 8 and 64) ▪ HI: 24-hour crisis telephone stabilization, crisis mobile outreach, crisis therapeutic foster home, community-based crisis group home, intensive in-home intervention, multi-systemic therapy (pp 47-59, 153-163) ▪ KY: crisis stabilization (Section 5 – 14) ▪ NV: crisis intervention (p 11) ▪ NC: mobile crisis management (pp 34 – 37) ▪ OR: children's crisis services (crisis prevention and intervention) (309-032-1265) ▪ RI: under CIS – intensive therapeutic treatment, crisis stabilization (pp 20-21); under CEDARR – crisis intervention services (pp 22-23) Parent coaching and education ▪ AZ: skills training and development and psychosocial rehabilitation living skills training, behavioral health prevention/promotion education and medication training and support services, home care training family, self-help/peer services (pp 45, 50, 87 89) ▪ GA: community support – individual, community support – team, family training/counseling, group training/counseling, intensive family intervention (pp 2, 15, 19, 53, and 68) ▪ HI: as a component of intensive in-home intervention and multi-systemic therapy (pp 153-163) ▪ KY: parent to parent service, therapeutic child support service (Section 5 – 6 and 7) ▪ NV: basic skills training includes as an activity parent education (p 15) ▪ NC: community support includes education and training of caregivers and others involved with the child (pp 29-33)	▪ Rhode Island – Certification Standards Providers of Home Based Therapeutic Services: June 2006 ▪ Rhode Island – Certification Standards Personal Assistance Services and Supports: September 27, 2004

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Wraparound Services Components	Other States' Covered Medicaid Behavioral Health Services	Source
	▪ OR: family support, case management, skills training (309-032-1265) ▪ RI: under CIS – intensive therapeutic treatment, therapeutic case management services (pp 21-22); under CEDARR – peer family support and guidance (p 22); Under HBTS – pre-treatment consultation (p47) Medication monitoring ▪ AZ: medication management (pp 67-75) ▪ FL: medication management (p 2-1-19) ▪ GA: under community support – individual, nursing assessment and health services and physician assessment and care, crisis stabilization program services (2, 31, 53 and 64) ▪ HI: medication management (pp 248-250) ▪ NV: medication management (p 10) ▪ OR: medication management and monitoring (309-032-1265) ▪ RI: under CIS – intensive therapeutic treatment (p 21) Intensive in-home ▪ FL: therapeutic behavioral on-site services (pp 2-1-34 – 42) ▪ GA: intensive family intervention (pp 68-72) ▪ HI: intensive in-home therapy, multi-systemic therapy (pp 153-163) ▪ NV: intensive outpatient program (p 10) ▪ NC: intensive in-home services (pp 42-46) ▪ OR: intensive community-based treatment and support services (309-032-1245) ▪ RI: under CIS – intensive therapeutic treatment (p 21); under HBTS – home-based specialized treatment (p 54) Individual, group and family therapy services: ▪ AZ: behavioral health therapy and counseling (pp 26-33)	

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Wraparound Services Components	Other States' Covered Medicaid Behavioral Health Services	Source
	▪ FL: brief individual medical psychotherapy, group medical therapy, individual and family therapy, group therapy (pp 2-1-19 – 21, 2-1-25 – 26) ▪ GA: family training/counseling, group training counseling, individual counseling (pp 15, 19 and 23) ▪ HI: individual therapy, group therapy, family therapy, functional family therapy (pp 251-270) ▪ KY: individual and group therapy (Section 5 – 3 and 4) ▪ NV: mental health therapies - individual, group and family (p8-9) ▪ NC: therapy (outpatient manual - pp. 7-8) ▪ OR: individual, group and family therapy (pp 2-10) ▪ RI: under CIS – intensive therapeutic treatment (p 21) Interactive psychotherapy using play equipment, physical device or other mechanisms of non-verbal communication ▪ AZ: interactive psychotherapy, interactive (CPT 90810-14) (pp 27-28) ▪ GA: interactive psychotherapy, interactive (CPT 90810-14) (p 23) ▪ NC: interactive psychotherapy, interactive (CPT 90810-14) (outpatient – p7) Individual rehabilitation services: ▪ AZ: rehabilitation services (pp 44-55) ▪ FL: psychosocial rehabilitation services, clubhouse services (pp 2-1-30 – 33) ▪ GA: community support – individual, family training/counseling, community support - team (pp 2, 15 and 53) ▪ HI: intensive in-home therapy, multi-systemic therapy, therapeutic foster home and multi-dimensional treatment foster care (pp 153-163, 176-187) ▪ KY: therapeutic child support service (Section 5 – 6) ▪ NV: rehabilitative mental health services, including basic skills training, case management, day treatment, psychosocial rehabilitation etc. (pp 15-18) ▪ OR: activity therapy, training and educational services related to care and	

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Wraparound Services Components	Other States' Covered Medicaid Behavioral Health Services	Source
	treatment of BH condition, skills training and development, foster care – therapeutic (pp 10, 14) ▪ RI: under CIS – intensive therapeutic treatment, therapeutic case management services, service coordination services (pp 21-22) ; under HBTS – treatment support, group intervention (pp 55-56); Under PASS – direct services (pp 37-38) Day rehabilitation ▪ AZ: behavioral health day programs (pp 151-159) ▪ FL: behavioral health day services (p 2-1-27) ▪ GA: child and adolescent mental health day treatment (p 46) ▪ KY: day treatment services, after school or summer program service (Section 5 – 8 and 9) ▪ NC: child and adolescent day treatment (pp 69-73) ▪ OR: community psychiatric supportive treatment program, behavioral health day treatment (p13) ▪ RI: under Kids Connect – therapeutic integration direct services (pp 25-26)	
Tracking and Adapting the Wraparound Service Plan	<u>Arizona</u> *Case management* activities include assistance in maintaining, monitoring and modifying covered services. The person's behavioral health practitioner is required to conduct and complete: 1) a review of progress that summarizes the person's progress toward meeting the objectives identified on the service plan and indicating any adjustments to the service plan; and 2) an annual behavioral health update and review summary that highlights the person's ongoing service needs, cultural preferences/considerations for service provision, current functioning, risk factors, identify additional assessment updates that are	Arizona Division of Behavioral Health Services Covered Services Guide – July 2007 p 78 Arizona Instruction Guide for the Assessment, Service Plan and Annual Update – 1/1/2006 pp 66-67

Wraparound Services Components	Other States' Covered Medicaid Behavioral Health Services	Source
	necessary and diagnostic information and adjustments that need to be made to the current service plan. Florida *Treatment plan review* is conducted to ensure that treatment goals, objectives and services continue to be appropriate to the recipient's needs and to assess the recipient's progress and continued need for services. The review requires participation of recipient and treatment team (see development of plan above). Hawaii Service plans have to be continually monitored and reviewed: ▪ The child's mental health care coordinator is required to convene comprehensive service plan meetings every six (6) months, or as clinically indicated and if there is a change in situation, in order to assure that the youth's needs are continually addressed and that service planning is modified as necessary. ▪ The service provider is required to regularly monitor and adjust treatment plans, with input from the youth, family/guardian, care coordinator and members of the youth's team. The providers must coordinate with family/significant others and with other system of care staff such as education, juvenile justice, and child welfare as needed to plan and provide services. Treatment strategies must be reviewed at least monthly and plans must be reviewed with the entire team at least quarterly (except where otherwise specified in the service-specific standards). *Treatment/service planning participation*, which is a covered service, includes in its definition the development, review, and modification of a MHTP, CSP, crisis	Community Behavioral Health Services Coverage and Limitations Handbook pp 2-1-18 Hawaii – Interagency Performance Standards and Practice Guidelines – Purple Book pp 10, 149, 241, 274

Wraparound Services Components	Other States' Covered Medicaid Behavioral Health Services	Source
	plan, discharge/transition plan, and other interagency treatment/service plans when specifically requested by the mental health care coordinator and is provided by a CAMHD Clinician. Also covered is *summary annual assessment* performed in order to describe the current status of the young adult or youth and his or her circumstances. It is performed yearly, when the CSP team determines that there are no clinical concerns that would call for a focused or comprehensive assessment to be performed instead. The service includes a brief assessment and report, with feedback to the young adult or youth and his/her parent(s) or guardian(s). <u>Kentucky</u> *Targeted case management* (covered service under Impact Plus) includes: ▪ Monitoring a child's progress and compliance with treatment ▪ Advocating for a child to ensure appropriate, timely and effective treatment and support services ▪ A monthly case management summary that includes progress in accessing services in service plan, progress towards goals, response to services. <u>Nebraska</u> The treatment plan must be reviewed and updated by the treatment team to ensure that services and treatment goals continue to be appropriate to the client's current needs, and to assess the client's progress and continued need for mental health services. <u>North Carolina</u>	Kentucky 907 KAR 3:030. Coverage and payment for IMPACT Plus services Nebraska HHS Finance and Support Manual 471 NAC 32-001.07

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	The state requires that there is a systematic method of reviewing the quality, appropriateness and comprehensiveness of the person centered plan a process for initiating plan revisions based on the results of the review. At a minimum it must be reviewed by the responsible professional based upon the target date assigned to each goal, whenever the consumer's needs change or when a service provider changes or before the goal expires. <u>Oregon</u> Under the rules for Children's Intensive Mental Health Treatment Services (ICTS): ▪ The service coordination plan must be reviewed and revised quarterly and when changes in service coordination planning occur, by the child and family team. ▪ The treatment plan must be reviewed and revised quarterly and when changes in treatment planning occur. ▪ There must be monthly summary progress notes by the care coordinator that document that the child and family team have discussed progress with treatment and service coordination planning an dif necessary convened a child and family team meeting to facilitate timely and appropriate service coordination planning. <u>Rhode Island</u> Under CIS standards, providers as part of treatment plan development and implementation are required to: ▪ Conduct treatment plan review(s) within the time frames set forth in the levels of care. These should consist of a review of the service goals, objectives, treatment intensity, indirect services and their subsequent effect	Enhanced mental Health and Substance Abuse Services pp 6-7 Oregon – Standards for Children's Intensive Community-Based Treatment and Support Services – 309-032-1285 Rhode Island – Standards for Providers of Children's Intensive Services: September 1, 2003 pp 31-32

Wraparound Services Components	Other States' Covered Medicaid Behavioral Health Services	Source
	on the child's level of functioning, as determined by Child and Adolescent Functioning Assessment Scale (CAFAS), CGAS and GARF. Reviews should be utilized, in concert with the utilization management process, to determine the appropriateness of the child's level of care. CEDARR also requires providers to provide *family care plan review* once per approved plan period. Progress in achieving the goals and objectives and the continuing appropriateness of the family care plan as written must be regularly reviewed and modified as appropriate. The outcome of the review must be a formal recommendation to the state as to continued approval or modification of the family care plan.	Rhode Island – Certification Standards fro CEDARR Family Centers: May 25, 2000 pp 25-26
Transition	<u>Arizona</u> Arizona's specific protocol for transitioning behavioral health recipients who turn 18, states: "…it is essential that transition to the adult system of care occur in a timely and seamless fashion so that behavioral health recipients experience continuity of care and necessary services are not interrupted. Title XIX/XXI children transitioning into the adult system upon turning age 18 should not experience a disruption of any needed behavioral health services…The Child and Family Team should begin establishing a transition plan to assure that appropriate measures are taken to provide for a smooth transition of care to adult services." Planning must still occur even if the Child and Family Team determines that the child no longer will need behavioral health services after he/she turns 18. Transition plans for these individuals will cover topics such as having independence from the system that has supported them, Medicaid eligibility, ensuring that the child has a place to live, job preparedness, etc. <u>Georgia</u>	Arizona Division of Behavioral Health Services Practice Protocol – Transitioning to Adult Services p 5

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	One of the eligibility criteria for determining if a youth qualifies for child and adolescent mental health and addictive disease services is an individual aged 18-19 who needs assistance with transitioning to adult services. In providing *child and adolescent mental health day treatment* providers are required to begin transition planning for less intensive service options at the onset of this service delivery. *Community support teams* are allowed to serve as a step down service for youth transitioning from *intensive family intervention* services or other higher levels of care, or for those with psychiatric hospitalizations/repeated substance use/abuse incidences in the past 18 months.	Georgia Provider Manual Part I, Section 1 for Mental Health and Addictive Services July 2006 - Core Benefit Package Section 1 (p 1) and pp 48 and 54
	<u>Hawaii</u> A transition/step-down component is contained within all treatment/service plans that informs all parties to the overall directions of treatment. The transition plan spells out the discharge criteria for any CAMHD service being procured and projected timeframe for that service. Additionally, the transition plan identifies any needed support or services that the youth/family will need to continue treatment in the least restrictive environment. *Transition planning for adulthood* is part of the mental health treatment plan (MHTP) developed by the service provider. The standard states: planning for a youth's transition to adulthood should begin early, e.g. ages 15-17. Youth and strength-driven goals should be continually refined and achieved in the following six (6) areas: 1) living arrangement/personal management, 2) vocational/educational, 3) mental health and medical, 4) community/social	Hawaii – Interagency Performance Standards and Practice Guidelines – Purple Book pp 10, 54, 59, 151, and 274

Wraparound Services Components	Other States' Covered Medicaid Behavioral Health Services	Source
	experiences, 5) financial support, and 6) employment. Transition to adulthood planning and implementation should be documented in the youth's CSP and/or MHTP for all youth aged seventeen (17) years and older. Providers of *crisis therapeutic foster home* and *community-based crisis group hom*e are required to develop a transition plan from the program if one does not exist for the child. *Treatment service planning participation* includes transition planning as a component of the service. <u>Kentucky</u> As part of *targeted case management(TCM),* a covered service under Impact Plus: ▪ The case manager is required to develop a plan of transition from Impact Plus services for a child. ▪ One unit of TCM is allowed to be authorized for delivery in the county to which the child shall be discharged from the therapeutic foster care placement or group residential placement prior to the anticipated discharge to home-based services. In addition transition planning is included as a part of: ▪ *Parent to parent support service* – providing assistance to child's parent, guardian or caregiver in development of and implementation of a plan to transition the child from Impact Plus services ▪ *Therapeutic child support service* – therapeutic intervention and support provided to a child transitioning to adulthood including an assessment of child's aptitude for vocational or skill training, monitoring of progress toward transition or assistance with developing skills and emotional readiness for an independent living setting.	Kentucky 907 KAR 3:030. Coverage and payment for IMPACT Plus services

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	▪ *Day treatment services, therapeutic group residential service* – includes transition planning and services designed to explore and link with community resources before discharge and to assist the child and family with transition to community services after discharge. <u>Nebraska</u> *Transition and discharge planning* is included as part of the state's standards related to the treatment planning: Throughout the client's care and whenever a client is transferred from one level of care to another, transition and discharge planning must occur and be documented. The focus of transition and discharge planning is to facilitate a timely transition out of the treatment system or to a less restrictive level of care. <u>Oregon</u> Under the rules for Children's Intensive Mental Health Treatment Services (ICTS): ▪ *Care coordination* which is a service component of intensive community-based treatment and support is the process oriented activity that provides ongoing communication and collaboration with children and families with multiple needs. One activity included under care coordination is providing for continuity of care by creating linkages to and managing transitions between levels of care and transitions for older youth to the adult service system. ▪ ICTS discharge criteria means the written diagnostic, behavioral, and functional indicators the child and family will meet to transition out of ICTS services as documented in a child's service coordination plan. ▪ ICTS discharge summary means a written document developed by the child	Nebraska HHA Finance and Support Manual Chapter 471 NAC 32-001.07A Oregon – Standards for Children's Intensive Community-Based Treatment and Support Services – 309-032-1245 (3), (20) and (21)

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	and family team that is completed prior to discharge from intensive community-based treatment and support services that is based on the service coordination plan. It includes: a review of service coordination planning; type and duration of services, supports, and levels of care utilized; concerns that arose during the planning process; and significant child and family accomplishments. The summary also includes recommendations about and planning to coordinate access to ongoing services and supports that would benefit the child and family as well as any other transition planning that will ensure continuity of care.	

Appendix B: Components of Therapeutic Foster Care

TFC Components	Other States' Covered Medicaid Behavioral Health Services	Source
Therapeutic Foster Care	States included in this review that specifically covered therapeutic foster care included:	
	▪ Arizona - Therapeutic Residential Support (in home, excluding room and board)[1]	▪ Arizona Division of Behavioral Health Services Covered Services Guide – July 2007
	▪ Florida – Specialized Therapeutic Foster Care Services	▪ Florida Community Behavioral Health Services Coverage and Limitations Handbook for Medicaid
	▪ Hawaii – Therapeutic Foster Home, Multidimensional Treatment Foster Care, Respite Therapeutic Foster Home (provides care to both custody and non-custody children)	▪ Hawaii – Interagency Performance Standards and Practice Guidelines – Purple Book
	▪ Kentucky – Treatment Foster Care Service (in addition Medicaid children in the custody of the state or at risk of being in custody of the state are eligible for other Impact Plus services).	▪ Kentucky 907 KAR 3:030. Coverage and payment for IMPACT Plus services
	▪ Nebraska – Treatment Foster Care Services	▪ Nebraska HHS Finance and Support Manual 471 NAC 32-005.04
	▪ New Mexico – Treatment Foster Care II	▪ New Mexico - Title 8 Social Services, Chapter 322 Enhanced EPSDT – Community Mental Health Services, Part 5 Treatment Foster Care II
	▪ Oregon – Treatment foster care is a mental health treatment setting in which home parents employed or contracted by supervising agency provide in-home psychosocial skills development to each child (primarily provided to custody children, although non-custody children are eligible). These children are also eligible to receive other intensive treatment services as well	▪ Oregon – Alternatives to State Hospitalization: Standards for Children's Intensive Mental Health Treatment Services – 309-032-1100 et al.

[1] Per discussions with CMS, the service name was changed from Therapeutic Foster Care services to Therapeutic Residential Support (in-home, excluding room and board). In turn, the service name in the Arizona Covered Services Guide was changed to Home Care Training to Home Care Client and a different HCPCS code was assigned to the services (S5145 (Foster Care Child, per diem) to S5109 (Home care training to home care client, per session). The nature and description of the service did not change.

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TFC Components	Other States' Covered Medicaid Behavioral Health Services	Source
	any other community-based treatment services (see ORS 430.630(3)) may be provided in a treatment foster care setting. ▪ South Carolina – Therapeutic Foster Care	▪ Oregon – Alternatives to State Hospitalization: Standards for Community Treatment Services For Children – 309-032-0950(84)-(85), et al. ▪ South Carolina Children's Behavioral Health Services Provider Manual
Recruitment and Matching	<u>Arizona</u> The protocol for *home care training to home care clients* (HCTC) states: Recruitment efforts should be made by the HCTC agency to license and train professional foster homes that are capable of meeting the needs of children needing HCTC services or have a current connection to a child who is in need of HCTC services…Factors that should be considered and prioritized when selecting a professional foster home who will be delivering HCTC services include: ▪ Adult already connected to and significant to the child ▪ Home most willing and able to meet the child's cultural and language needs ▪ Intensity of needs of child should be coordinated with capabilities of foster family. <u>Florida</u> The service standards for specialize therapeutic foster care services require: ▪ A multi-disciplinary team to assess whether or not the child requires specialized therapeutic care services and the level of services required by the child. ▪ Specialized therapeutic foster parents to be specially recruited and trained in interventions designed to meet the individual needs of the child	Arizona Division of Behavioral Health Services Practice Protocol – Home Care Training to Home Care Client Services for Children pp 4-5 Florida Community Behavioral Health Services Coverage and Limitations Handbook for Medicaid pp 2-3-4, and 2-3-5

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TFC Components	Other States' Covered Medicaid Behavioral Health Services	Source
	Hawaii In the service definitions included in the strategic plan for *multi-dimensional treatment foster care,* it states that the "*multidimensional treatment foster care* implementers recruit, train and supervise foster families to offer youth treatment and intensive supervision at home, in school and in the community. Nebraska Requires TFC supervisor to provide support and consultation to the treatment team and caseworker and among their responsibilities are: ▪ Treatment parent recruitment ▪ Training and selection Program has to have written policy explaining the procedures and criteria for treatment parent selection. South Carolina For therapeutic foster care one of the services that is identified as an integral component of TFC and should be provided by the provider agency is placement of a child with a TF parent specifically matched to meet the child's individual needs.	Hawaii – Children and Adolescent Mental Health Division Strategic Plan 2007-2010, Appendix E p 3 Nebraska HHS Finance and Support Manual 471 NAC 32-005.04 South Carolina Children's Behavioral Health Services Provider Manual p 2-99
Foster Parent Training	Arizona In addition to being licensed, HCTC service providers are required to receive additional training as set forth in the ADHS/DBHS Provider Manual Section 9.1, Training Requirements (e.g., behavioral management, HCTC curriculum training), prior to providing services. Pre-training activities associated with the HCTC setting is included in the rate and may not be billed outside the HCTC procedure code rate.	Arizona Covered Services Guide pp 92-94 DBHA Protocol: Home Care Training to Home Care Client Services for Children, AZ Department of Health Services pp 7,

Appendix B: Components of Therapeutic Foster Care

TFC Components	Other States' Covered Medicaid Behavioral Health Services	Source
	Arizona requires that all HCTC parents receive pre-service training, ongoing training, supervision, and support from the professional HCTC agency. Supervision and training of the HCTC family by a licensed professional has been built into the procedure code rate.	and 10
	<u>Florida</u> The service standards for specialized therapeutic foster care services require: ▪ Provider agencies of specialized therapeutic foster care to have an approved pre-service and in-service training plan for staff providing specialized TFC services. ▪ Specialized therapeutic foster parents to be specially recruited and trained in interventions designed to meet the individual needs of the child. ▪ Clinical staff to be assigned to each child in TFC and this person must supervise and support the TF parents; provide in-service training to the TF parents, evaluate and assess children receiving services, and supervise performance of TF parents. ▪ Home visits as often as necessary to support the foster parent(s) and child in making progress toward the treatment goals. *Therapeutic behavioral on-site behavior management service*s, which is a service intended to maintain the child/adolescent in the home (biological or foster) includes training caregivers and other involved persons in the implementation of the behavior plan.	Florida Community Behavioral Health Services Coverage and Limitations Handbook for Medicaid pp 2-3-2, 2-3-5, 2-3-6, 2-3-7, 2-3-11-12, 2-1-34 and 2-1-39
	<u>Hawaii</u> Training of foster parents is part of the provider standards for each of the covered therapeutic foster care services. Examples include that foster families receive: ▪ 20 hours of initial orientation ▪ 20 hours of ongoing training annually related to the mental health needs of	Hawaii – Interagency Performance Standards and Practice Guidelines – Purple Book pp 176-187

TFC Components	Other States' Covered Medicaid Behavioral Health Services	Source
	the youth ▪ 2 hours a month of supervision from a mental health professional In addition, two of the services identified as offered under *therapeutic foster home* are: ▪ Evidence-based treatment training, including positive behavioral support training, for the therapeutic foster care parents as well as for the family of origin. ▪ Treatment team face to face meetings with the specialized therapeutic foster parents in order to monitor the youth's progress and to discuss treatment strategies and services. <u>Kentucky</u> Requires therapeutic foster parent to: ▪ Complete 30 hours of pre-service training using a curriculum approved by the state. ▪ Receive 24 hours of annual training related to the care of a child with complex treatment needs. ▪ Receive a documented face-to-face supervision and support in the therapeutic foster care home every other week by a behavioral health professional or a behavioral health professional under clinical supervision who is employed by a child-placing agency. <u>Nebraska</u> Treatment parent training must be systematic, planned and documented process which includes competency-based skill training and is not limited to the provision of information through didactic instruction. It should prepare treatment parents to carry out their responsibilities as agent to the treatment process. The training must include: ▪ Pre-service training that is provided prior to placement of children in their	Kentucky 907 KAR 3:030. Coverage and payment for IMPACT Plus services Nebraska HHS Finance and Support Manual 471 NAC 32-005.04C3,. 04C4 and .04A2

TFC Components	Other States' Covered Medicaid Behavioral Health Services	Source
	homes and includes basic and agency specific training. ▪ In-service training that includes a minimum of 12 hours annually and emphasizes skill developments as well as knowledge acquisition. Treatment foster care programs are required to provide intensive support, technical assistance and supervision to all treatment parents. This includes peer support – facilitating the creation of support networks for treatment foster families. TFC specialists must provide support/consultation to treatment parents that includes: ▪ Regular support and technical assistance to the treatment parents in their implementation of the treatment plan and with regard to other responsibilities they undertake. The fundamental components of technical assistance are the design or revision of in-home treatment strategies including proactive goal setting and planning, the provision of ongoing child-specific skills training and the problem solving during home visits. ▪ Other types of support/supervision, including emotional support and relationship building, the sharing of information and general training to enhance professional development, assessment of the client's progress, observation/assessment of family interactions and stress, and assessment of safety issues. <u>Oregon</u> Requires treatment services provided in therapeutic group home and treatment foster care settings to be delivered by QMHPs and QMHAs with experience and training in psychosocial skills development and milieu therapy under the direction of a qualified mental health professional in consultation with a psychiatrist. Under the rules for children's intensive community-based treatment and support	Oregon – Alternatives to State Hospitalization: Standards for Children's Intensive Mental Health Treatment Services – 309-032-1150(10) Oregon – Standards for Children's

TFC Components	Other States' Covered Medicaid Behavioral Health Services	Source
	services, *skills training* is a covered service. This includes providing parenting information and behavior support training and planning to parents or caregivers as well as skills development for children and transitional youth. It may include developing and strengthening competencies that include but are not limited to areas such as anger management, stress reduction, conflict resolution, self-esteem, parent-child interactions, peer relations, drug and alcohol awareness, behavior support, managing symptoms, and adapting the home and other settings to mitigate triggers to maladaptive behavior. The goal of this service is to maintain a stable living environment, positive interpersonal relationships, and participation in developmentally appropriate activities. (NOTE: family includes foster parents). <u>South Carolina</u> TFC services are defined as behavioral, psychological and psychosocial in orientation. TF parents are specially recruited and trained in behavioral management and treatment interventions designed to meet the individual needs of the child. The TFC provider is required to ensure that the TF parent meet the training requirements specified for each TFC level. In addition the provider agency is required to provide to the TF parents psychological or psychiatric consultation regarding a specific child's problems or needs and/or the lead clinical staff on an as-needed basis but at least every six months for Level II and at least quarterly for Level III.	Intensive Community-Based Treatment and Support Services – 309-032-1245(39) South Carolina Children's Behavioral Health Services Provider Manual pp 2-92, 2-96 and 2-99.
Development of Treatment Plan	<u>Hawaii</u> For all eligible children, two linked service plans are developed: ▪ *Coordinated Service Plan (CSP*. The CSP builds upon the strengths of the youth and family and is developed with full engagement and involvement of youth, family/guardian, and key individuals involved in the youth's life including existing or potential service providers.	Hawaii – Interagency Performance Standards and Practice Guidelines – Purple Book pp 10, 176-187

TFC Components	Other States' Covered Medicaid Behavioral Health Services	Source
	▪ *Mental Health Treatment Plan (MHTP)* The development, implementation, review, revision and adjustments to the MHTP are the responsibility of the service provider. MHTP is individualized for each youth and is an ongoing collaborative process driven by the family/guardian and youth that includes the Contractor, family and the mental health care coordinator (MHCC). Specifically for children receiving therapeutic foster home services, the provision of these services must be based on measurable goals and objectives that are part of the youth's CSP and MHTP. The CSP must identify the service and measurable objectives for the outcomes of this service prior to admission. <u>Kentucky</u> The Impact Plus care plan must specify modality, frequency, intensity and duration of services, who will manage the continuity of care, interventions by caregivers, problems with intervention and objective measurable goals, discharge criteria, crisis action plan, and plan for transition. In addition for therapeutic foster care, the development and monitoring of a collaborative service plan must include: 1) an individualized behavior management plan, 2) a plan for the involvement and visitation of a child with the birth family, guardian and 3) services and planning beginning at admission to facilitate discharge of a child to an identified plan for home-based services. <u>Nebraska</u> The TFC specialists is the practical leader of the treatment team and works in development of the treatment plan, supports and consults with the treatment families, client families and other members of the treatment team. The TFC specialist is required to: ▪ Take primary responsibility for the preparation of each client/family's written comprehensive treatment plan and the written updates of the plan. ▪ Inform and involve other team members in this process including treatment	Kentucky 907 KAR 3:030. Coverage and payment for IMPACT Plus services Nebraska HHS Finance and Support Manual 471 NAC 32-005.04A2, 04C1 and .08

TFC Components	Other States' Covered Medicaid Behavioral Health Services	Source
	parents and the client family. Treatment foster care providers are required to encourage family members to be involved in the assessment of the client, the development of the treatment plan and all aspects of the client's treatment unless prohibited by the client, through legal action or because of federal confidentiality laws. The treatment parents are required to assist the team in development of treatment plans for the client/family in their care; contributing vital input based upon their observations of the client/family in the natural environment of the treatment home. The treatment plan is required to include short and long term goals, therapeutic interventions (frequency and by whom), estimate length of stay and placement and discharge plan. <u>New Mexico</u> A treatment plan must be developed by a treatment team in consultation with recipient, biological, foster or adoptive family or legal guardian, physician, if applicable and others in whose care the recipient is involved. The plan must describe: ▪ Specific problem, needs and strengths ▪ Functional level of recipient ▪ Conditions for least restrictive conditions necessary to achieve purposed of treatment ▪ Intermediate and long-range goals and rationale for achieving ▪ Responsibilities of staff and TFC parents and frequency ▪ Criteria to release The following services must be performed by the treatment foster care agency or be contracted for: assessment of the recipient and his biological, foster or	New Mexico 8.322.5.14 – Treatment Plan New Mexico 8.322.5.12 – Covered Services

TFC Components	Other States' Covered Medicaid Behavioral Health Services	Source
	adoptive family's strengths and needs; development of a discharge plan that includes a strengths and needs assessment of the recipient's family, when a return to that family is planned, and development and monitoring of the treatment plan. <u>Oregon</u> The rules for children's intensive mental health treatment services of which treatment foster care is included in the range of service components in the system of care, provide that: ▪ An individual plan of care is developed for each child receiving intensive treatment services. This is defined as the written plan developed by a QMHP for active treatment for each child admitted to an intensive treatment service program. The individual plan of care specifies the DSM diagnosis, goals, measurable objectives, and specific treatment modalities and is based on a completed mental health assessment or comprehensive mental health assessment of the child's functioning and the acuity and severity of psychiatric symptoms. ▪ There is an interdisciplinary team of qualified treatment and education professionals including a child and adolescent psychiatrist or LMP and the child's parent or guardian responsible for assessment and evaluation, the development and oversight of individual plans of care, and the provision of treatment for children admitted to an intensive treatment services program. ▪ Providers must demonstrate family involvement and participation in all phases of assessment, treatment planning and the child's treatment In the SPA for *targeted case management services (TCM)* for OYA and SOSCF children who reside in an in-home setting, a foster home, group home, residential care facility or independent living situation, TCM includes: ▪ Assessment: After the need for targeted case management services has been determined, , the case manager assesses the specific areas of concern, family strengths and resources, community resources and extended family resources	Oregon – Alternatives to State Hospitalization: Standards for Children's Intensive Mental Health Treatment Services – 309-032-1110(40 and 44) and 1120 Oregon – Medicaid State Plan Amendment – Attachment 3.1.-A for Targeted Case Management - Supplement 1

TFC Components	Other States' Covered Medicaid Behavioral Health Services	Source
	available to resolve those identified issues. At assessment, the case manager makes preliminary decisions about needed medical, social, educational, or other services and level of agency intervention. ▪ Case Planning: The case manager develops a case plan, in conjunction with the client and family, to identify the goals and objectives which are designed to resolve the issues of concern identified through the assessment process. Case planning includes setting of activities to be completed by the case manager, the family and client. This activity will include accessing medical, social, educational, and other services to meet the client's needs. ▪ Case Plan Implementation: The case manager will link the client and family with appropriate agencies and medical, social, educational or other services through calling or visiting these resources. The case manager will facilitate implementation of agreed-upon services through assisting the client and family to access them and through assuring the clients and providers fully understand how these services support the agreed-upon case plan.	
Tracking and Adapting the Treatment Plan	<u>Florida</u> The responsible clinical staff for *specialized therapeutic foster care services* are required to: ▪ Conduct regularly scheduled face-to face meetings with the specialized therapeutic foster parents in order to monitor the child's progress and discuss treatment strategies and services ▪ Conduct monthly visits to other community settings to observe the child's behavioral, psychological and psychosocial progress and to coordinate intervention ▪ Evaluate and assess children who are receiving services A psychiatrist must interview the child to assess progress toward meeting treatment goals and update the treatment plan on an as needed basis but at least quarterly for Level I and monthly for Level II.	Florida Community Behavioral Health Services Coverage and Limitations Handbook for Medicaid pp 2-3-6 and 2-3-7

Appendix B: Components of Therapeutic Foster Care

TFC Components	Other States' Covered Medicaid Behavioral Health Services	Source
	Hawaii Services offered under *therapeutic foster home* and *multidimensional treatment foster car*e include: ▪ Treatment team face to face meetings with the specialized therapeutic foster parents in order to monitor the youth's progress and to discuss treatment strategies and services. ▪ Coordination with school personnel to implement and provide academic support in the foster home setting for the youth. ▪ MTFC parent daily report to maintains daily contract with all foster parents in order to monitor progress via the collection of behaviorally based data (MTFC only) The service provider is required to do a *summary annual assessment*. This assessment is performed in order to describe the current status of the young adult or youth and his or her circumstances. It is performed yearly, when the CSP team determines that there are no clinical concerns that would call for a focused or comprehensive assessment to be performed instead. The service includes a brief assessment and report, with feedback to the young adult or youth and his/her parent(s) or guardian(s). Nebraska The treatment plan must be reviewed by the multi-disciplinary team at least every 30 days. The treatment parents must keep a systematic record of the client/family's behavior and progress in targeted areas on a daily basis. The team's progress notes must contain a concise assessment of the client/family's progress and recommendations for revising the treatment plan, as indicated by the client/family's condition, and discharge planning. New Mexico	Hawaii – Interagency Performance Standards and Practice Guidelines – Purple Book pp 176-187 and 241-243 Nebraska HHS Finance and Support Manual 471 NAC 32-005.04C and .08 New Mexico rules – 8.322.5.12 Covered

Appendix B: Components of Therapeutic Foster Care

TFC Components	Other States' Covered Medicaid Behavioral Health Services	Source
	The TFC provider agencies are required to perform the following services: ▪ Develop and monitor the treatment plan ▪ Assess the recipient's progress in TFC ▪ Assess the TFC family's interaction with the recipient, his or her biological, foster or adoptive family and any stressors identified	Services
	The treatment coordinator must review the treatment plan every 30 days.	New Mexico rules – 8.322.5.14 Treatment Plan
	<u>Oregon</u> In the SPA for *targeted case management services (TCM)* for OYA and SOSCF children who reside in an in-home setting, a foster home, group home, residential care facility or independent living situation, TCM includes: ▪ Case Plan Coordination: After these linkages have been completed, the case manager will ascertain, on an ongoing basis, whether or not the medical, social, educational, or other services have been accessed as agreed, and the level of involvement of the client and family. Coordination activities include, but are not limited to, personal, mail and telephone contacts with providers, and well as meetings with the client and family to assure that services are being provided and used as agreed. ▪ Case Plan Reassessment: The case manager will determine whether or not medical, social, educational or other services continue to be adequate to meet the goals and objectives identified in the case plan. Reassessment decisions include those to continue, change or terminate those services. This may include assisting clients to access different medical, social, educational or other needed services beyond those already provided. Reassessment activities include, but are not limited to, staffings and mail, personal, and telephone contacts with involved parties.	Oregon – Medicaid State Plan Amendment – Attachment 3.1.-A for Targeted Case Management - supplement 1

Appendix B: Components of Therapeutic Foster Care

TFC Components	Other States' Covered Medicaid Behavioral Health Services	Source
Plan Implementation	<u>Arizona</u> The definition of HCTC services states that these services are provided by a foster parent/family to a person residing in his/her home in order to implement the in-home portion of the person's behavioral health service plan. HCTC services assist and support a person in achieving his/her service plan goals and objectives….Based on the behavioral health recipient needs additional support services may be billed such as personal care, skills training and development. The HCTC standard requires that ongoing case management and coordination among all involved child family team members (behavioral health, licensing agency, custodial agency, health plan) should ensure that: 1) the behavioral health service plan is well developed and fully implemented, 2) there is a timely response to the behavioral health needs within the professional foster home, and 3) there is access to indicated behavioral health supports. <u>Florida</u> Requirement of TFC states: specialized therapeutic foster parent serve as the primary agent in the delivery of therapeutic services to child. <u>Hawaii</u> *Therapeutic foster home services* are defined as an intensive community-based service. The homes provide a normative, community-based environment through therapeutic parental supervision, guidance and support. The service offers the following services: ▪ Intake evaluation and informal assessment ▪ Evidence-based treatment training, including behavioral support training ▪ Treatment team meetings ▪ Skills development activities ▪ Supportive counseling	Arizona Covered Services Guide pp 92-94 DBHS Practice Protocol: Home Care Training to Home Care Client Services for Children, AZ Department of Health Services p 6 Florida Community Behavioral Health Services Coverage and Limitations Handbook for Medicaid p 2-3-5 Hawaii – Interagency Performance Standards and Practice Guidelines – Purple Book pp 176-187

TFC Components	Other States' Covered Medicaid Behavioral Health Services	Source
	▪ Coordination with school ▪ Evidence-based family therapy ▪ Active on-going treatment for child focused on returning the youth home ▪ Active evidence-based individual therapy ▪ Crisis stabilization *Multidimensional treatment foster care services* are intensive family-based services and use the foster parents to provide the youths with close supervision, fair and consistent limits and consequences, a supportive relationship and minimal association with peers that have been a bad influence. The service offers the following services: ▪ Intake and assessment ▪ Maintenance of collateral contacts with care coordinator ▪ Crisis management 24 hours 7 days a week. ▪ Closely supervised behavioral intervention by foster parents ▪ Face to face team meetings ▪ Daily contact with foster parent ▪ Coordination by foster parent with school ▪ Individualized pro-social activities coaching by peer counselor ▪ Individual therapy ▪ Family therapy ▪ Active on-going treatment for child focused on returning the youth home <u>Nebraska</u> Treatment foster family is viewed as the primary treatment setting; with treatment parents trained and supported to implement the in-home portion of the treatment plan and promote the goals for permanency planning for children in their care. The treatment parents provide the main behavioral intervention and are available at all times. They have the primary responsibility for implementing the interventions identified in the treatment plan.	Nebraska HHS Finance and Support Manual 471 NAC 32-005.01, .04A2, and .04C1

Appendix B: Components of Therapeutic Foster Care

TFC Components	Other States' Covered Medicaid Behavioral Health Services	Source
	The TFC specialist is required to take an active role in identifying goals and coordinating treatment services provided to the youth. <u>New Mexico</u> Therapeutic family living experience is the core treatment service to which other individualized services can be added. TF parents: ▪ Have primary responsibility for implementing the in-home treatment strategies as specified in individualizes treatment plans ▪ Help recipients maintain contact with families ▪ Support efforts specified by treatment plan to meet recipient's permanency planning goals ▪ Assist recipients to obtain other necessary services The TF provider agency are required to: ▪ Facilitate age-appropriate skills development in the areas of household management, nutrition, physical, behavioral and emotional health, basic life skills, social skills, time management, school and/or work attendance, money management, independent living skills, relaxation techniques and self-care techniques ▪ Ensure the occurrence of counseling or therapy sessions for recipients in individual, family and/or group sessions as specified in the treatment plan ▪ Ensure the availability of crisis intervention. <u>Oregon</u> In the SPA for *targeted case management services (TCM)* for OYA and SOSCF children who reside in an in-home setting, a foster home, group home, residential care facility or independent living situation, TCM includes: ▪ Case Plan Implementation: The case manager will link the client and family with appropriate agencies and medical, social, educational or other services through calling or visiting these resources. The case manager will facilitate	New Mexico Rule 8.322.5.12 – Covered Services Oregon – Medicaid State Plan Amendment – Attachment 3.1.-A for Targeted Case Management - supplement 1

TFC Components	Other States' Covered Medicaid Behavioral Health Services	Source
	implementation of agreed-upon services through assisting the client and family to access them and through assuring the clients and providers fully understand how these services support the agreed-upon case plan. *Intensive mental health treatment services* providers are required to ensure that the following services are available to the child who is also eligible to receive all community treatment services defined in ORS 430.630(3): ▪ Psychiatric and psychological assessment and treatment ▪ Individual, group and family therapies ▪ Medication evaluation, management and/or monitoring ▪ Pre-vocational/vocational rehabilitation; ▪ Therapies supporting speech, language and hearing rehabilitation; ▪ Individual and group psychosocial skills development; ▪ Behavior management; ▪ Activity and recreational therapies; ▪ Nutrition; ▪ Physical health care services or coordination; and ▪ Case management, treatment planning and coordination, and consultation Providers of *therapeutic treatment foster care services* are specifically required to maintain linkages with primary care physicians, applicable educational agencies CMPHs and MHOs, SCF or OYA representatives and the child's parent(s) or guardian to coordinate related services and after care resources for the child.	Oregon – Alternatives to State Hospitalization: Standards for Children's Intensive Mental Health Treatment Services – 309-032-1150
Family Treatment	<u>Arizona</u> *Home care training family services (family support)* involve face-to-face interaction with 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 person in the home and community. The service may involve support activities such as assisting the family to adjust to the person's disability, developing	Arizona Covered Services Guide p 87

TFC Components	Other States' Covered Medicaid Behavioral Health Services	Source
	skills to effectively interact and/or manage the person, understanding the causes and treatment of behavioral health issues, understanding and effectively utilizing the system, or planning long term care for the person and the family. <u>Florida</u> For *specialized therapeutic foster care services*, the clinical staff are responsible for preparing and training the child's biological or legal parents to resume care of their child when reunification is the goal. For *therapeutic group home* the providers must provide family therapy or counseling with the clinician or contact with the child's guardian, at least weekly, based on the child's treatment needs and permanency plan… <u>Hawaii</u> Family treatment is a component of the services provided *though therapeutic foster home (TFH) and multidimensional treatment foster care (MTFC) services*. ▪ For TFH: weekly evidence-based family therapy services are provided to the family of origin of each youth in placement as indicated on the youth's plan. The therapist's role is to support the family with an emphasis on family-based implement ation of individualized behavioral approaches developed in the TFH setting. The program meets weekly with the parents of origin, from the first week the youth begins foster care placement until the youth transitions out of foster care placement, to provide parent education, information and skill building as necessary for them to implement the evidence-based interventions in the home of origin that have been found to be effective for the youth. Where custody has been permanently removed from the family of origin, or where long-term foster custody has been arranged with an identified DHS foster family and the youth will not be returned to the home setting, a DHS identified adult/parental figure able to assume long-term parenting responsibilities will participate in the weekly family therapy sessions.	Florida Community Behavioral Health Services Coverage and Limitations Handbook pp 2-3-6 and 2-6-5 Hawaii – Interagency Performance Standards and Practice Guidelines – Purple Book pp 176-187

Appendix B: Components of Therapeutic Foster Care

TFC Components	Other States' Covered Medicaid Behavioral Health Services	Source
	▪ For TFH and MTFC: Active, on-going treatment for the youth is based on the measurable goals and objectives that are part of the CSP and MHTP. The treatment is focused on returning the youth home. Where DHS holds permanent custody or where long term foster custody has been arranged with an identified DHS family, these goals are integrated with the permanency plans and/or support successful transition of the youth to ongoing DHS foster care or to an independent living program. ▪ For MTFC: the MTFC Family Therapist provides weekly evidence based therapy to the youth's family of origin with an emphasis on family-based implementation of individualized behavioral approaches developed in the MTFC setting. <u>Nebraska</u> Part of TFC program is family treatment. TFC programs also serve the families of the children and adolescents in their care. TFC programs seek to involve children and families in treatment-planning and decision making as members of the treatment team. They provide family services to children and their families when return home is planned and actively seek to support and enhance children's relationships with their parents, siblings and other family members throughout the period of placement regardless of the permanency goal unless such efforts are expressly and legally prohibits. <u>Oregon</u> Under its standards for intensive community-based treatment and support services it includes: ▪ *Family therapy* which is provided by a qualified mental health professional who has a child and adolescent mental health background and experience providing community-based intensive services to families. ▪ *Family support* which is the provision of support services, including support to caregivers at community meetings, assistance to families in system	Nebraska HHS Finance and Support Manual 417 NAC 32-005.01 Oregon – Standards for Children's Intensive Community-Based Treatment and Support Services 309-032-1245 (17), (18), (24) and (39) and 309-032-1265

TFC Components	Other States' Covered Medicaid Behavioral Health Services	Source
	navigation and managing multiple appointments, supportive home visits, peer support, parent mentoring and coaching, advocacy7 and furthering efforts to develop natural and informal community supports. ▪ *Skills training* which includes providing parenting information and behavior support training and planning to parents or caregivers as well as skills development for children and transitional youth. It may include developing and strengthening competencies that include but are not limited to areas such as anger management, stress reduction, conflict resolution, self-esteem, parent-child interactions, peer relations, drug and alcohol awareness, behavior support, managing symptoms, and adapting the home and other settings to mitigate triggers to maladaptive behavior. The goal of this service is to maintain a stable living environment, positive interpersonal relationships, and participation in developmentally appropriate activities. NOTE: Family includes biological or legal parents, siblings, other relatives, foster parents, legal guardians, caregivers and other primary relations to the child.	
Transition	<u>Arizona</u> All planned transitions from the professional foster home delivering HCTC services must be included in the service plan. Coordination between families, agencies, providers and community supports should begin in advance of an anticipated move, and as soon as a change or transition is considered. Transitions should be implemented in a manner that minimizes change and best prepares the child and family members for the future. In addition, all information that can facilitate a successful transition should be shared. The transition plan should include…: ▪ Face to face meetings ▪ Graduated visits, overnights stays ▪ Comprehensive exchange of information between families/providers about	Arizona Division of Behavioral Health Services Practice Protocol – Home Care Training to Home Care Client Services for Children pp 8-9

TFC Components	Other States' Covered Medicaid Behavioral Health Services	Source
	the child's strengths and needs ▪ Updates to crisis/safety plan ▪ Support and rehabilitation services that will support child in their new environment ▪ Ongoing contact with supportive and anchoring relationships in the child's current community <u>Florida</u> During last three months prior to a planned discharge a child's biological family or other permanent placement, Medicaid will reimburse for a graduated number of therapeutic visits. <u>Hawaii</u> The focus of treatment under *therapeutic foster car*e and *multidimensional treatment foster care* is to return the youth home. When the state hold permanent custody or where long term foster custody has been arranged, these goals are integrated with the permanency plan and/or support successful transition of the youth to ongoing state foster care or to an independent living program. Service exclusions are waived when a youth will be transitioned out of therapeutic foster home and into the identified service within 30 days referral. <u>Kentucky</u> As part of *targeted case management* (a covered service under Impact Plus): ▪ The case manager is required to develop a plan of transition from Impact Plus services for a child. ▪ Allows one unit of TCM to be authorized for delivery in the county to which the child shall be discharged from the therapeutic foster care placement or	Florida Community Behavioral Health Services Coverage and Limitations Handbook for Medicaid p 2-3-13 Hawaii – Interagency Performance Standards and Practice Guidelines – Purple Book pp 176-187 Kentucky 907 KAR 3:030. Coverage and payment for IMPACT Plus services

TFC Components	Other States' Covered Medicaid Behavioral Health Services	Source
	group residential placement prior to the anticipated discharge to home-based services.	

Sources

Name of Source	Web Site	Type of Source
Arizona Division of Behavioral Health Services Covered Services Guide – July 2007	http://www.azdhs.gov/bhs/covserv.htm	Manual describes individual services provided to Medicaid and SCHIP eligible individuals. Only a few of the services, e.g., room and board are not covered with Medicaid dollars.
Arizona Instruction Guide for the Assessment, Service Plan and Annual Update – 1/1/2006	http://www.azdhs.gov/bhs/provider/sec13.htm	This guide provides instruction as to how to use the standardized tools for conducting assessments, developing service plans and conducting annual updates on persons enrolled in the DBHS behavioral health system.
Arizona Division of Behavioral Health Services Practice Protocol – Home Care Training to Home Care Client Services for Children – June 1, 2007	http://www.azdhs.gov/bhs/guidance/guidance.htm	This protocol outlines the clinical considerations related to providing HCTC services to Title XIX/XXI eligible children.
Arizona Division of Behavioral Health services Technical Assistance Document 3 – The Child and Family Team Process – Rev January 10, 2006	http://www.azdhs.gov/bhs/guidance/guidance.htm	This technical assistant document describes the Child and Family Team process and ADHS' expectation for the application of this approach with every enrolled Title XIX/XXI child. Examples of billing codes from the Covered Services Guides that can be used to bill for these activities are provided in an attachment.
Arizona Division of Behavioral Health Services	http://www.azdhs.gov/bhs/guidance/guida	This protocol outline the steps needed to ensure

Sources

Name of Source	Web Site	Type of Source
Practice Protocol – Transitioning to Adult Services – July 1, 2004	nce.htm	the timely and seamless transition of all enrolled children (Medicaid and state only) into the adult service system.
Florida Community Behavioral Health Services Coverage and Limitations Handbook for Medicaid - 10/04	http://floridamedicaid.acs-inc.com/index.jsp?display=handbooks	Agency for Health Care Administration, via ACS, has Medicaid handbooks that provide providers with policies and procedures, explaining covered services and policies for each type of Medicaid Service.
Georgia Provider Manual Part I, Section 1 for Mental Health and Addictive Services July 2006 - Core Benefit Package	http://mhddad.dhr.georgia.gov/portal/site/DHR-MHDDAD/	Service definitions in the DHR program manual are referred to in the Medicaid provider manuals.
Georgia Medicaid Manuals: Community Mental Health Services (2/16/07)	https://www.ghp.georgia.gov/wps/portal/	Medicaid and PeachCare for Kids provider manuals providing program policies and procedures.
Hawaii – Interagency Performance Standards and Practice Guidelines – Purple Book June 1, 2006 (printed)	http://www.hawaii.gov/health/mental-health/camhd/library/webs/ipspg/ipspg.html	An integrated manual, jointly developed by DOH-CAMHD and the DOE, for use in the development and provision of behavioral health/mental health services to children who a) have been certified as qualifying under Individuals with Disabilities Educational Act (IDEA) for special education services; and/or qualifying under Section 504 – Subpart D of the

Name of Source	Web Site	Type of Source
		Rehabilitation Act of 1973; and who are in need of related behavioral/mental health services to benefit from their free and appropriate public education; and b) children who meet the eligibility requirements for the DOE/CAMHD Support for Emotional and Behavioral Health (SEBD) program. (The SEBD is for Medicaid or Quest eligible youth with intensive mental health needs to access comprehensive community-based health care.)
Hawaii – Children and Adolescent Mental Health Division Strategic Plan 2007-2010 (November 2006)	http://www.hawaii.gov/health/mental-health/camhd/library/webs/camhdplan/camhdplan2.html	Appendix E provides brief service definitions for the SEBD Program. Medicaid pays for services listed under 1) Educationally Supportive Intensive Mental Health Services and 2) Support for Emotional and Behavioral Development Program Services. Per CAMHD SEBH program director Medicaid is currently not covering peer support, parent skills training, intensive outpatient treatment for co-occurring substance abuse and may also not be covering family court testimony, intensive outpatient services for independent living skills, and community hospital crisis stabilization. These are services that the state would like to see covered under its SPA in the future.
Kentucky 907 KAR 3:030. Coverage and payment for IMPACT Plus services	http://www.lrc.ky.gov/kar/907/003/030.htm	These are Kentucky's administrative rules for the IMPACT Plus program which is a Medicaid

Sources

Name of Source	Web Site	Type of Source
		program. The Program Manager indicated that the rules provide the most current description of the Medicaid covered services provided through this program.
Kentucky – state web page on Impact Plus Program	http://mhmr.ky.gov.mhsas/Impact%20Plus.asp?sub1	Web page contains description of program and forms such as care plan and progress report.
Kentucky Medicaid State Plan ▪ Attachment 3.1.A – page 7.6.1 (11/1/82) ▪ Supplement 1 Attachment 3.1.-A – page 7 (6/21/01)	http://chfs.ky.gov/dms/state.htm	Includes coverage of rehab option and targeted case management services for children in custody of or at risk of being in the custody of the state and for children under the supervision of the state.
Nebraska Description of Mental Health and Substance Abuse Services in Medicaid/SCHIP on web	http://www.hhs.state.ne.us/med/medserv.htm	Web page with description of covered Medicaid/SCHIP services.
Nebraska HHS Finance and Support Manual – Chapter 32-000 Mental Health and Substance Abuse Treatment Services for Children and Adolescents - Rev October 15, 2003	http://www.hhs.state.ne.us/reg/t471.htm	Nebraska Health and Human Services Support Manual for Medicaid covered services – Title 471 Nebraska Medical Assistance Program Services
Nevada Medicaid Services Manual: ▪ Chapter 400 – Behavioral Health (3/2007)	http://dhcfp.state.nv.us/MSM%20Table%20of%20Contents.htm	Medicaid services and policies that govern these services are set forth in this manual.

Sources

Name of Source	Web Site	Type of Source
▪ Chapter 2500 – Targeted Case Management (9/2003)		
New Mexico Interagency Behavioral Health Service Requirements and Utilization Guidelines 4/1/2006 – Comprehensive Community Support Services	http://www.bhc.state.nm.us/servicedef.html	Service definitions are used by the collaborative agencies and Medicaid is one of the sources of funding for these services.
New Mexico - Title 8 Social Services, Chapter 322 Enhanced EPSDT – Community Mental Health Services, Part 5 Treatment Foster Care II	http://www.nmcpr.state.nm.us/NMAC/	The rules are specifically for New Mexico's Medicaid program (recompiled 11/30/01).
North Carolina, Division of Medical Assistance - Enhanced Mental Health and Substance Abuse Services Manual - 4/1/2007	http://www.dhhs.state.nc.us/dma/bh/8A.pdf	North Carolina Department of Health and Human Services, Division of Medical Assistance Manual describing policies and procedures that providers must follow to receive reimbursement for covered enhanced benefit behavioral health services provided to eligible Medicaid recipients.
North Carolina Division of Medical Assistance – Outpatient Behavioral Health Manual – 6/1/2007	http://www.dhhs.state.nc.us/dma/mp/mpindex.htm	North Carolina Department of Health and Human Services, Division of Medical Assistance Manual describing policies and procedures that providers must follow to receive reimbursement for covered enhanced benefit behavioral health services provided to eligible Medicaid recipients.

Sources

Name of Source	Web Site	Type of Source
Oregon – Medicaid State Plan Amendment – Attachment 3.1.-A for: ▪ Rehabilitative Mental Health Services (13.d) – approved 11/96 ▪ School-Based Rehabilitative Services (13.d) – approved 2/05 ▪ Behavior Rehabilitation Services (13.e) - approved 2/05 ▪ Targeted Case Management (supplement 1) – approved 5/17/99 and 2/26/04	http://www.oregon.gov/DHS/healthplan/tools_policy/sp_3.pdf	State's Medicaid State Plan: There are a number of groups that are covered under targeted case management, including: ▪ Children under 21 years residing in an in-home setting, foster home, group home, residential care facility or independent living situation under the responsibility of State Office for Services to Children and Families (SOSCF – manages child welfare programs) or Oregon Youth Authority (OYA – manages programs for youth corrections, parole etc). ▪ Medicaid members seeking or obtaining BH services from participating local mental health authorities.
Oregon – 430.630 Services to be provided by community mental health and developmental disabilities program; local mental health authorities; local mental health services plan.	http://www.leg.state.or.us/ors/430.html	Oregon statute for Alcohol and Drug Abuse Programs (Chapter 430)
Oregon – Alternatives to State Hospitalization: Standards for Community Treatment Services For Children – 309-032-0950 et al.	http://arcweb.sos.state.or.us/rules/OARs_300/OAR_309/309_032.html	Oregon administrative rules for community mental health treatment services for children (including Medicaid) within a comprehensive system of care.

Sources

Name of Source	Web Site	Type of Source
Oregon – Standards for Children's Intensive Community-Based Treatment and Support Services – 309-032-1240 et al.	http://arcweb.sos.state.or.us/rules/OARs_300/OAR_309/309_032.html	Oregon administrative rules for intensive community based treatment and support services within the continuum of mental health care for children (including Medicaid) with serious mental, emotional and behavioral disorders and their families.
Oregon – Alternatives to State Hospitalization: Standards for Children's Intensive Mental Health Treatment Services – 309-032-1100 et al.	http://arcweb.sos.state.or.us/rules/OARs_300/OAR_309/309_032.html	Oregon administrative rules for community mental health treatment services for children (including Medicaid) within a comprehensive system of care. Includes coverage of treatment foster care.
Oregon Health Plan Mental Health: Medicaid Procedure Codes and Reimbursement Rates for Services Provided On or After 7/1/07	http://www.oregon.gov/DHS/mentalhealth/publications/codebooks/mh-rates070107.pdf	Service codes and service criteria used for billing Medicaid for Medicaid covered services. Services listed under Oregon Health Plan/Managed Care are encounter services only and are not "covered" for FFS population and thus should not be used as examples of Medicaid services covered under a State Plan. Services listed under Non-OHP Medicaid services are however, considered covered Medicaid, but are paid for on a FFS basis.
Rhode Island – Standards for Providers of Children's Intensive Services: September 1, 2003	http://www.dhs.ri.gov/dhs/famchild/CIS%20standards.pdf	Certification standards for providers of children's intensive services to Medicaid eligible children with serious emotional and/or

Name of Source	Web Site	Type of Source
		behavioral disturbances.
Rhode Island – Certification Standards fro CEDARR Family Centers: May 25, 2000	http://www.dhs.ri.gov/dhs/cedarr/Certification%20Standards.pdf	Certification standards for providers of CEDARR (comprehensive evaluation, diagnosis, assessment, referral and reevaluation services and supports) program initiative services (EPSDT-based) to Medicaid eligible children. Certification is based on clinical expertise in behavioral health as well as other areas such as autism, developmental. Pages 2 and 5 state that these enhanced services are available for children and families pursuant to federal EPSDT requirements.
Rhode Island – Certification Standards Therapeutic Child and Youth Care: April 15, 2003 (known now as Kids Connect)	http://www.dhs.ri.gov/dhs/famchild/TCYC%20standards.pdf	Certification standards for providers of therapeutic child and youth care to Medicaid eligible children living at home with special health care needs (physical, developmental, behavioral or emotional conditions) as well as children living with foster family. (CEDARR Direct Service)
Rhode Island – Certification Standards Providers of Home Based Therapeutic Services: June 2006	http://www.dhs.state.ri.us/dhs/famchild/HBTS_standards.pdf	Certification standards for providers of home based therapeutic services to Medicaid eligible children living at home with significant impairments in functioning (have or at risk for chronic physical, developmental, behavioral or

Sources

Name of Source	Web Site	Type of Source
		emotional conditions) as well as children living with foster family. (CEDARR Direct Service) Since the mide-1990's this services has been provided to certain children under the provision of EPSDT (p 33)
Rhode Island – Certification Standards Personal Assistance Services and Supports: September 27, 2004 Rhode Island – Personal Assistance Services and Supports (PASS) Fact Sheet	http://www.dhs.ri.gov/dhs/famchild/pass_final.pdf Provided by Rhode Island	Certification standards for providers of consumer-directed PASS services to Medicaid eligible children living at home with special health care needs (have been diagnosed with certain physical, developmental, behavioral or emotional conditions). (CEDARR Direct Service) High level description of PASS. (CEDARR Direct Service)
South Carolina Medicaid Children's Behavioral Health Services Provider Manual - 6/07/07	http://www.dhhs.state.sc.us/dhhsnew/ServiceProviders/ProviderManualsAll.asp?pType=ChildrenBehavioralHealth	South Carolina Department of Health and Human Services is the state Medicaid agency. This is one of a number of Medicaid manuals they have developed to describe requirements for delivering of Medicaid services.